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NURSE CASE MANAGERS IN THE ACUTE CARE SETTING:

A QUALITATIVE DESCRIPTIVE STUDY

by

COLLEEN A. CARMODY

Thesis submitted to the

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Nurse Case Managers in the Acute Care Setting: A Qualitative Descriptive Study.

Thesis directed by Associate Professor JoAnn G. Congdon.

Nursing Case Management has evolved from a nursing care delivery model into a patient care delivery system. The nurse case manager is responsible for coordinating and monitoring the patient's care for an entire episode of illness. Nurse case manager's success depends on appropriate preparation and training. Despite the popularity of the case management model, limited knowledge exists about the preparation and training of nurse case managers working in acute care settings.

The purpose of this qualitative descriptive study was to describe the preparation and training of nurse case managers from the perceptions of the nurse case managers in acute care settings. The specific aims of this study were to: (a) describe the preparation that helped the nurses transition into a case management role in acute care settings, (b) describe how the nurse case managers were trained to implement the goals of case management, (c) describe those aspects of the nurse case manager's practice environment that facilitate or are barriers to achieving expected patient outcomes, and (d) generate nursing knowledge to enhance the education and preparation of nurse case managers.

This study is significant because knowledge about the perceptions of current case management preparation and training may help explain how well educational programs provide the necessary knowledge and skills for nurses to carry out case management activities. This knowledge may assist nurse educators in redesigning nursing school

curricula for baccalaureate and master's degree students to meet health care needs in the 21st century.

Using a qualitative descriptive design, data were generated from a purposeful convenience sample of 8 nurse case managers from two Denver area metropolitan acute care settings. All participants had a range of 1-7 years of experience as a nurse case manager. Data were generated from audiotaped semi-structured interviews and field notes. Data management and organization was assisted by use of a computer software program, The Ethnograph. The coded data were analyzed into categories and themes. The themes were: (1) Moving the Patient through the System by Creative Problem Solving, (2) Expertise in Clinical Practice is Key to Success for Nurse Case Management Role, and (3) Overcoming Specific Barriers to Achieve Expected Patient Outcomes.

In an era in which cost, quality care, and access present increasing problems, the results from this study strengthened the belief that nurses are ideal for the role of case manager based on their education and clinical expertise in a nursing specialty. Training for a nurse case management role is evolving and continues to be on-the-job and institution specific. Most barriers to continuity of care faced by the nurse case managers are the lack of education about managed care among health care providers and systems problems within the health care institution. The case managers had a major role in education of patients, families, and hospital staff about the aspects of managed care in order to facilitate timely, unfragmented, appropriate, and quality patient care. Conclusions drawn from this study may have been different from case managers working in private hospitals.

Outcomes research is needed to show the effectiveness of the nurse case manager in acute care settings and to justify reimbursement for nurse case management practice by insurance mechanisms.

The form and content of this abstract are approved.

Signed Jean G. Cooper
Faculty member in charge of thesis

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CHAPTER I

INTRODUCTION

The escalation of U. S. Health Care costs and the increasing fragmentation of the health care delivery system have created a national mandate for managed care systems that both reduce costs and improve quality health care (Bach, Smeltzer, & Baler, 1996). In 1988, 550 billion dollars were spent on health care in the United States (NLN, 1989). That is 11.5% of the gross national product for that year. Since 1980 costs have risen about 10.5% annually. Advances in technology, restructuring of payment strategies for health care, reduced lengths of hospital stay, an aging population, increasing numbers of chronically ill clients, and alternative sites for care are some of the factors contributing to dramatic changes in the health care system (Bower, 1988). The record does not permit us to say that Americans are receiving better health care as a result of our exorbitant health care expenditures (Maraldo & Fagin, 1992).

Managed care is one solution to the crisis in health care spending. The purpose of managed care is to provide the appropriate use of health care services. Managed care places a third party into the provider/patient relationship to assist in the process of health care delivery. This third party in collaboration with the physician and patient helps decide what health care services are needed, when they are needed, and how to access them. Managed care offers unprecedented opportunities for nurses to function as gatekeepers to improve quality and continuity of care as well as containing costs within the context of a changing health care environment. Such an environment has been viewed as nursing's best opportunity to produce key constituencies including patients and

families, care providers, health care organizations, and payers (Zander, 1988a).

A fundamental requirement for effective managed care is case management systems that coordinate and oversee the clinical process of care for defined patient populations (Bach, et. al., 1996). Nursing case management is a model of patient care delivery and the management of resources that enables the strategic management of cost and quality by clinicians for an episode of illness or throughout the continuum of care (Blouin, Lewis, Malone, & Metz, 1996).

According to the American Nurses Association (1988):

> Case management is a system of health care delivery designed to facilitate achievement of expected patient outcomes within an appropriate length of stay. The core features of this care delivery model include assessment, planning, linkage, advocacy, and monitoring (Maurin, 1990). The goals of case management are the provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the client's quality of life, efficient utilization of patient care resources, and cost containment (ANA, 1988).

Case management is driven by the belief that quality in health care is a product, not a service. It is also driven by the premise that the cost of producing a range of expected outcomes can be understood and revised on a case-type basis (Zander, 1988a). Using a client-focused strategy case management coordinates care while maintaining a balance between cost, outcomes and the process of health care delivery. Case management has traditionally been viewed as a way for health care professionals to ensure that patients received needed health care services, it is increasingly being used by payers of health care as a means of containing costs (Jacox, 1992). Case managers monitor the type and amount of care received to see that the most effective methods are used and that appropriate technologies are used and not wasted. It is hoped that in any model of case

management a collaborative relationship among all disciplines will prevent the duplication of services, potential crisis is avoided, and the least restrictive setting is used for care, and cost savings will be realized (ANA, 1988).

Nursing case management forces all levels of nursing to focus less on internal problems and more on formal links for the patient between the institution and external agencies and programs. In essence, the nurse case manager must be committed to the client and the institution. The core features of this care delivery model include assessment, planning, linkage, coordination of services, and monitoring. Fundamental to nursing case management is the belief that the case management role is best filled by a clinician who is in a direct care, hands-on relationship with the patient and family. Nurses are the most appropriate health care professionals to serve as case managers, coordinating care across settings. The evidence suggests that nurses are also the ideal providers to determine the need for home care, long-term care, and care in the community, since many of the problems clients have to do with activities of daily living (Grau, 1984). Nurses understand the 24 hour health care needs of the client and family. As well as coordinating health care delivery, nurse case managers are responsible for monitoring the costs and quality outcomes for their case management activities.

Further, for managed care to result in improved outcomes for clients, as contrasted with cost savings for insurance companies, nurses must have the authority to allocate resources devoted to that care (Maraldo & Fagin, 1992). The essence of nursing case management is the formation of a relationship between the nurse case manager and the patient and family, and the other health care providers. The emphasis is to give

significant assistance in accessing appropriate health services, vigorous outreach, and assisting clients in reaching their highest level of functioning in the least restrictive setting.

Statement of the Problem

Limited knowledge exists about the preparation and training of unit-based nurse case managers working in acute care settings. There are several educational programs for case management outlined in the literature but, very little evidence of their effectiveness on the preparation and training of nurse case managers. Case management is a popular patient care delivery model for nursing care in the 1990s, even though it has been loosely defined in the literature and has different meanings and many variations in the way the system is implemented. There is no clear agreement about definition and component activities of nursing case management (Lamb, 1992). Hence, there is no unified formal education to prepare nurses for case management activities. The job description for case managers in settings such as insurance companies, Health Maintenance Organizations, ambulatory care, community health care clinics, home and long-term settings, and acute care may vary, however the roles and necessary skills needed of a case manager are very similar (McNeese-Smith, et. al., 1996). Much of the research has measured the structure, process, and outcomes of case management as opposed to the actual delivery system and the preparation of case managers. There is minimal research from the perceptions of the nurse case managers about their training and preparation for such a responsible position in the health care delivery system.

Nursing care delivery models, which are modifications of primary or team nursing

have evolved in acute care settings and are often called case management programs (Lyon, 1993). The success or failure of the nursing case management models is primarily in the hands of the nurse case managers. Success is dependent on their education, preparation, and training. Currently, most nursing case management training is clinically-based and institution specific. For the client, the nature of the case manager's formal education in management and access to resources in the social system, influences the kind of direct care, quality monitoring, and cost-effectiveness the case manager provides.

For nursing care delivery systems to achieve selected outcomes and function cost-effectively, there must be clarification, formal education, and standardization for nurse case managers in all settings. The more we understand case management from the case manager's point of view the more likely we will be to redesign and formulate a unified case management patient care delivery model. Hence, nursing professionals will be able to define their unique role as a case manager and write their own job description and not be used as a service coordinator to control costs. Otherwise, nurse case managers may become cost containment agents instead of nursing care managers.

Purpose and Specific Aim

The overall purpose of this research was to describe the training and preparation perceived by unit-based nurse case managers in acute care settings for their case management role.

The specific aims of this descriptive study were to:

1. Describe the preparation that helped the nurses transition into unit-based case managers in an acute care setting.
2. Describe how the nurse case managers were prepared to implement the goals of case management.
3. Describe those aspects of the nurse case manager's practice environment that facilitate and/or are barriers to achieving expected patient outcomes.
4. Generate nursing knowledge to enhance the education and preparation of nurse case managers.

Significance of the Study

The crux of the research is demonstrated by the significance of the study (Marshall & Rossman, 1989). Nursing's leadership in case management reflects nursing's tradition of coordinating various resources to meet client's multiple service needs. Nursing Case Management has become a popular patient care delivery system in the 1990s. Knowing nurse case managers are receiving the knowledge and skills to provide quality, timely, unfragmented, cost-effective, and individualized care is vital to the client's they manage. Previous research on case management has focused on cost-effectiveness, patient and nurse satisfaction, case management models, and care outcomes. This study was significant because it focused on the described perceptions about what previous research has only presumed. This study provided knowledge about effectiveness of the current case management preparation and training in use at two major medical centers. Information received in this study may identify relevant education that is needed to carry

out case management activities. Knowledge gained about case management preparation and training may describe which educational programs are the most effective in providing the necessary knowledge and skills for nursing case management. The study may identify curriculum in training for a nurse case manager. This knowledge may assist nurse educators to redesign nursing school curricula for baccalaureate and master's degree students to meet the needs of our client's in the 21st century.

Today, case management education programs are developed to provide nurses who are selected to assume case manager roles with the knowledge and skills necessary for success in such roles (Tahan, 1996). The Joint Commission on Accreditation of Health care Organizations (JCAHO) stresses the importance of orientation programs, in-service education, and competency of staff providing health care services. Training and education programs are necessary in organizations to establish the competency of nurses who assume the new roles. Competency has been defined as the way a nurse actually performs in a particular situation. Competency describes how well that nurse integrates his or her knowledge, attitudes, skills, and behaviors in delivering care according to expectations (Tahan, 1996). In an era in which cost, quality, and access present increasing problems, findings from this study may strengthen the belief that nurses are ideal for the role of case manager based on their education and experience with the nursing process and knowledge about the health problems of people throughout their life span.

The core features of nursing case management incorporate the nursing process, linkage, advocacy, and monitoring. Beyond these core features there is a great variety in

the operational definition of case management. One fundamental philosophical and operational difference in the various models is whether case management is viewed as a clinical or an administrative process (Maurin, 1996). Some models span the continuum of a client's episode of illness while others focus on acute or community nursing case management. Cost outcomes, as well as quality outcomes, such as increased self-esteem, and self care activities have been realized by all models. There is considerable evidence in the literature that there are many variations in the way case management is implemented. This study may add to the body of knowledge on case management and provide a clearer understanding of program purposes among health care professionals and consumers.

Case management has been referred to as "enduring care" (ANA, 1988). Case management is defined by the ANA (1988) as the process of planning, organizing, coordinating, and monitoring services and resources needed to respond to the individual's health care needs. The implementation of case management by a nurse is much the same as using the nursing process. The functions of case management are both facilitating and gatekeeping in that the goals are to provide quality, comprehensive care to patients while containing costs (Maurin, 1996). The literature had little discussion about the issues that must be problematic in the case management patient care delivery process. Such conflicts might be between case managers and primary physicians, relationships with other nurses, or obstacles on the unit itself. This study may uncover any such barriers to patient care delivery and coordination of services. Organizational theory suggests that to achieve desired health care outcomes it is necessary to find the optimal fit between a care delivery

system's structure and the environment in which the system must function (Allred, Arford, Nichel, Dring, Carter, & Veitch, 1995). Knowledge about the aspects of the case manager's practice environment that facilitate and/or are barriers to desired health outcomes may be beneficial to case management coordinators, staff development nurses, nurse managers, and those nurses beginning their case management role.

Nursing case management elevates the primary care nurse to a position of more authority and autonomy within an organization whereby the professional goals of collaboration and accountability become clearly defined and can actually be translated into practice (Tahan, 1996). According to Zander (1990) staff nurses will gain interpersonal skills, acute assessment skills, and be more satisfied and empowered to improve patient care as they transition to a case management position. Zander further stated these same nurses will need formal education in management and access to the social systems to be able to handle resources and set up lines of communication. This research study intended to increase our understanding of the nurse's transition into the case manager role. Knowledge about the nurse's transition may add to information that influence nursing education, satisfaction, turnover, retention, and recruitment.

Significance of a study arises from a judgment that what we know collectively as a discipline is not enough, and is grounded in a sufficient review of the literature to document that the study will contribute to knowledge in some way. It was not the purpose of this study to completely fill in a knowledge gap in the preparation and training of nurse case managers. That would be impractical from the view point that knowledge changes and must be recreated anew forever (Boyd & Munhall, 1993).

Definition of Terms

Unit-based nurse case management - case managers follow patients on a particular unit of the hospital.

Case management model - a methodology for organizing patient by identifying a particular population (high-risk, high-volume, high-cost), addressing care needs through an entire episode of illness so efficient, effective, quality care and financial outcomes are achieved within an allotted time frame (Bower, 1992).

Managed care - a clinical system that organizes and sequences the care-giving process at the client-provider level to better achieve cost and quality outcomes. Managed care provides continuity of plan by linking tasks, shifts, and departments (Zander, 1990).

Nurse Case management - the actual mobilization, monitoring, and rationalization of resources that client's use over a course of illness; attempts to connect previously unconnected parts of the health care system to form a continuum of care by linking people across clinical settings (Zander, 1990).

Nurse case manager - carries a caseload of patients but may not be responsible for daily hands-on care; collaborates with the primary care giver and interdisciplinary team for access, daily planning, coordination of care and services, monitoring the plan of care, and evaluating outcomes of health care (Bower, 1992).

Practice environment - the information, resources, and/or relationships nurses regard as most important to providing patient care.

Historical Perspective on Case Management

The development of case management in the United Stated is best correlated with industrialization and urbanization (Kersbergen, 1996). As our population grew, so did our health care delivery system, resulting in fragmentation and duplication. The process of case management began in the 1860s in response to the growth and lack of coordination in the health care provided the poor and immigrants. The term "case management" was coined in the 1960s by the federal government to describe programs designed to promote coordination of services.

Historically, the process of managed care has been present in the practice of most clinicians throughout the 19th and 20th centuries. Case management has existed since nurses began working in patient's homes at the turn of the century, social workers organized resources for the underprivileged, and surgeons directed the activities surrounding a case through surgery (Zander, 1988b). American Public Health Nursing was founded by Lillian Wald in the 1890s. The first public health nurses worked autonomously to organize and mobilize family and community resources while providing direct patient care. The community health nurses in the early 1900s provided and coordinated nursing care, house keeping services, social services, spiritual care, and meeting the needs of the family as a whole. With the Civil Rights Movement came a change in the relationship between the client and the provider. The provider became accountable to the consumer for the quality of services.

Formal application of managed care via case management began with social services clients, mentally ill patients, and rehabilitation patients. Deinstitution of the mentally

disabled in the 1970s had a major impact on the case management process. These persons were now dependent on a complex, uncoordinated, community support system. Service coordination through case management was mandated for each client with the passage of the Developmentally Disabled Assistance and Bill of Rights Acts of 1975 and 1978 (Kersbergen, 1996). During the 1970s the concept spread to social welfare literature and practice (Giuliano & Poirier, 1991).

Case management expanded into other health care service areas because of escalating costs and the introduction of Diagnostic Related Groups (DRGs) in the 1980s. Expense control became more important to health and social services after the introduction of DRGs and other third-party pay cost reduction strategies. The DRGs created reimbursement incentives for decreased lengths of hospital stays by paying for care by case rather than by the services provided. In acute care settings, discharge planning, case management and utilization review became the tools for managing constraints brought on by DRGs. During this time the focus of case management began to shift toward providing more efficient and cost-effective patient care while maintaining high quality outcomes. Case management also became the process to coordinate and facilitate services for the elderly as they were discharged from the hospital into the community setting. During the 1980s, case management programs were utilized by insurance companies to control costs and scrutinize health care. The insurance industry's implementation of case management, emergence of Health Maintenance Organizations, and preferred provider organizations led to prospective payment systems that have affected health care consumers.

One of the most current case management programs was started at the New England Medical Center Hospital (NEMCH) in the 1980s. The New England Medical Center Hospitals are considered the pioneers of centering case management on nurses (Giuliano & Poirier, 1991). The goal of the NEMCH was to achieve clinical and financial outcomes with DRGs allotted lengths of stay (LOS) using a "critical path" timeline. A comprehensive documentation tool known as a "care map" is also part of this case management program.

The long history of case management provides a strong foundation for the refinement of case management programs to meet the needs of consumers in the 1990s.

Background of Case Management

A second generation of primary nursing, named Nursing Case Management in 1985 by New England Medical Center Hospitals, was the first official recognition of the staff nurse's role in managing care in hospitals. Interest in case management in acute care settings stems from a shortage of professional nurses, with resulting changes in skill mix found in hospitals today (Maurin, 1990). Nursing's contributions to managing care include the evolution of the nursing process, nursing diagnosis, and primary nursing. Through these innovations nurses have managed patients along a continuum from admission to discharge and are accountable for measurable clinical outcomes.

Nurses assuming the role of case manager require in-depth knowledge and skills. The requirements are generic, transcending the issues of where or by whom the case manager is employed (Bower, 1992). Case management has grown so quickly that there are insufficient well-prepared individuals for this role. Many resourceful individuals have

gained on the job training to enable them to step into this role. The advanced training and education on the concept and implementation of case management remains clinically-based and institution specific. There is no consensus about the appropriate training and education required to be a nurse case manager. As yet, there are no degrees in nursing case management. However, there are master's degree programs in nursing with tracks in case management. The American Nurses Association recommends that the minimum preparation for a nurse case manager is a baccalaureate in nursing with 3 years of appropriate clinical experience (Bower, 1992). Despite the baccalaureate in nursing being the minimum educational preparation required for case managers, many programs prefer master's prepared nurses who are clinical specialists in areas of the targeted population served. Nursing administration graduates are gaining leadership positions in case management programs. Clinical nurse specialists are choosing to include finance and systems management skills into their practice to be able to function in a case management role. A well-planned program is required to prepare the nurse case manager to support quality of patient care, promote the effective use of resources, decrease the length of stay, and maximize reimbursement to the organization (Fralic, 1992). The best preparation is a strong background in a clinical area and broad preparation in finance, utilization review, the management of systems, management of information systems, interpersonal skills, and leadership (McNeese-Smith, Anderson, Misseldine, & Meneghini, 1996).

A baccalaureate in nursing is preferable, but equivalencies in the following areas could serve equally well: (1) knowledge and use of the nursing process, (2)

collaborative relationships with other nurses, with physicians, and with patients and their families and, (3) excellent management skills as shown by management of self, shift change responsibility, and case loads (Zander, 1990). In addition to the academic and practice criteria, the nurse should be assessed for a track record of (a) taking initiative and following through with complex problems, (b) effective communication skills, (c) ability to be either a follower or a leader in a group, and (d) interested in the welfare of the institution and the community it serves (Zander, 1990). Case managers need to have expert knowledge and skills that staff nurses have not completely developed. Zander (1988) identifies these skills as:

- background knowledge about prospective payment and current insurers
- skill in family assessment
- skill in assessing patients at high risk for complications
- skill in setting goals with patients and their families
- skill in collaborating at the attending level, and running health care team meetings
- skill in using physician rounds for monitoring critical paths
- skill in presenting cases for consultation
- knowledge about telephone triage
- knowledge about home health care and resources
- skill in auditing outcomes concurrently

Nursing case management elevates the primary nurse to a position of more authority within an institution where by the professional goals of collaboration and accountability become clearly defined and can actually be translated into practice (Zander, 1988).

Chapter Summary

Since its endorsement by the American Nurses Association, nursing case management has become an accepted framework of practice for nurses (Rheaume, Frisch, Smith, & Kennedy, 1994). Nursing realizes clients need assistance in using the health care system effectively. By adopting case management programs, nurses are attempting to decrease the fragmentation of services and improve the quality of health care through an entire episode of illness. The functions of case management are both facilitating and gatekeeping in that the goals are to provide quality, coordinated care through an entire while containing costs. The hope is to prevent duplication of services, crisis, and the least restrictive setting is used for health care in the most cost-effective manner.

Depending on the model of case management being implemented the case manager may provide some direct patient care or delegate care to a team of technical or auxiliary nursing staff. The responsibility for patient care may begin before admission and includes follow-up after discharge from the acute care setting.

The 1990s role in nursing will put nurses in the center of the cost/quality/access challenge (Zander, 1990). With case management nurses are using their knowledge and clinical expertise to help institutions reform patient care per case type across an entire episode of illness. Case managers are eliminating fragmentation of health care delivery and pulling together all related professionals to decrease length of hospital stays while ensuring quality patient care and positive outcomes. It is always in the best interest of the patient to minimize the time required to achieve optimal clinical outcomes. Institutions want to achieve similar objectives, thus minimizing cost and maximizing the client

throughout an episode of illness (Fralic, 1992).

Nursing case management must be about designing care that provides integration of patient services, a coordinated plan of care, and continuity of care so that patients receive the highest quality of health possible for a cost that is reasonable and attainable. (McNeese-Smith, Anderson, Misseldine, & Meneghini, 1996). For nursing case management, as a patient care delivery system, to achieve selected outcomes and function cost-effectively, case managers must be educated and prepared to be able to appropriately implement and evaluate quality health care.

The overall purpose of this research was to describe the preparation and training perceived by unit-based nurse case managers in acute care settings for their case management role. The significance of this study was to advance fundamental knowledge in the discipline of nursing. This study may be useful to nursing practice, in that it may reduce confusion and clarify the preparation and training for case management as perceived by nurse case managers. The rich, subjective data gained from this qualitative descriptive study may identify the relevant education required to carry out the nurse case manager's role activities. The study was appropriate for qualitative research because it sought to explain the subjective perceptions about preparation and training for nurse case managers.

The following chapters in this thesis address the related literature and the research methodology. Chapter II includes a critical review of literature on case management education. Chapter III describes the methodology of the study. The methodology includes a description of the specific research design, sampling procedure, sample size,

data collection, and data analysis procedure. Chapter IV presents the results of data obtained from open-ended, semi-structured interviews with nurse case managers. Chapter V discusses results based on the study. Future recommendations for research, implications for nursing practice, and limitations of the study are presented.

CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature serves four broad functions. First, if possible, it should describe the assumptions and values the researcher brings to the study. Second, it demonstrates the researcher is knowledgeable about related research and intellectual traditions that support the study. Third, it shows how the proposed study will attempt to fill in gaps of the previous research. Finally, the review redefines the research questions through larger empirical traditions (Marshall & Rossman, 1989). The literature review supports the importance of the study's focus and may serve to validate the findings from this qualitative research study. The major concepts of this study were the preparation and training of unit-based nurse case managers in acute care settings for their case management activities. Case management has a long history of use in a variety of settings with the mentally ill, elderly patients, and in the community setting. Case management services have been in place and studied in public health, mental health, and long-term care settings and reported in the literature for many years (Lyon, 1993). To provide a basis for understanding the concepts of preparation and training of nurse case managers, the review of the literature in this study was organized into two sections, theoretical and empirical. The theoretical section included several educational programs and strategies that have been used to prepare and train case managers. The empirical section presented the few studies that have been done to measure the preparation and training of nurse case managers from any type of health care setting, not specifically acute-care.

Theoretical Literature

The profound changes in reimbursement practices have created a much-needed catalyst for an equally profound restructuring of traditional care delivery systems and practice patterns at every level of acute-care institutions (Zander, 1988). The shift from "hi-tech" to "hi-speed" care must be addressed with specific organizational solutions which start from a detailed knowledge of the production process at the care provider level (Zander, 1988). Nursing Case Management, both a patient care delivery model and set of technologies for the strategic management of cost and quality health care along a continuum and across settings, provides these solutions.

According to the American Nurses' Association (ANA)(1988), the minimum preparation recommended for the nurse case manager is a baccalaureate in nursing with three years of appropriate clinical experience. This preparation is in accord with the requirements in the ANA publication The Scope of Nursing Practice, which identifies the baccalaureate as preparation for the full scope of the clinical practice of nursing (ANA, 1988). A baccalaureate degree in nursing coupled with the appropriate clinical experience is also consistent with the ANA's Standards of Home Health Nursing Practice, and Standards and Scope of Gerontological Nursing Practice, which describe coordination of services and case management as a function of the nurse generalist (ANA, 1988). In 1988, the ANA stated that baccalaureate nursing programs prepared nurses to adequately meet the health needs of complex, high-risk clients in case management programs. However, few existing educational programs provide nurses with all the knowledge and skills needed to successfully function in the role of case manager. The

ANA (1988) submitted nurses often need additional education or experience in client assessment, community resource assessment, service coordination, networking, and advocacy in order to be competent case managers. The ANA (1988) further stated many nursing educational curricula will have to be revised to be able to prepare baccalaureate degree nurses with adequate theoretical background in case management. Nursing school curricula may need to provide financial management and business, and systems management education for nurses who want to work as nursing case managers.

The American Nurses' Association has defined continuing education as: learning activities intended to build upon the educational and experience bases of the professional nurse for the enhancement of practice, education, administration, research or theory development to the end of improving the health of the public. Continuing education programs are much shorter in length than in-service education. The ANA defined inservice education as: activities intended to assist the professional nurse to acquire, maintain, and/or increase competence in fulfilling the assigned responsibilities specific to the expectations of the employer. Workshops of four or more hours in length are generally considered to be continuing education offerings (Costello, 1992).

The 1996 Joint Commission on Accreditation Manual for Healthcare Organizations (JCAHO) requires an orientation process providing initial job training and assessment of each staff member's ability to fulfill specific responsibilities. The process familiarizes staff members with their jobs and with the work environment before the staff begin patient care and other activities. JCAHO (1996) requires on-going in-service and other education and training to maintain and improve staff competence. The ongoing in-service

and other education and training programs must also be appropriate to patient age groups served by the hospital. Another standard of JCAHO (1996) is that the hospital encourages and supports self-development and learning for all staff. Besides assessing staff competence, the hospital leaders must create a work environment that helps staff members discover what they need to learn and acquire new knowledge and skills (JCAHO, 1996).

Bower (1992) submitted that although a baccalaureate in nursing is the minimum educational preparation recommended by the American Nurses Association for case managers, many existing case management programs prefer master's-prepared nurses who are experienced clinical nurse specialists in areas related to the target population, and who have worked in the types of service settings the case manager is most likely to encounter.

Bower (1992) referred to the Nursing Assessment and Management of the Frail Elderly (NAMFE) curriculum for nursing case managers in community-based and long-term care of the elderly being tested at the University of Kansas School of Nursing, Kansas City, Kansas to meet the educational needs of case managers. She suggested with appropriate leveling of content the NAMFE curriculum could assist other schools of nursing to integrate additional case management knowledge and skills into existing undergraduate and graduate programs. The concepts of Dorothea Orem's self-care model were integrated throughout the NAMFE curriculum to maximize the self-care potential of the individual, family, and the community (Bower, 1992).

Bower (1992) outlined the knowledge and skills essential to functioning as a case

manager and proposes using these knowledge sets to develop a curriculum for new case managers. Bower (1992) provided an excellent resource for nurse case manager's working in different case management settings and supported formal educational preparation for nursing case managers.

Haw (1995) described a master's degree program in case management/long-term care initiated in 1991 at the School of Nursing at San Francisco State University. The program was on of the first in the country to take a broad view of long-term care to include client populations from infancy through old age and to prepare nurses at the graduate level in the case management role. Haw (1995) offered the methods for developing the program, identified major areas of professional competence in case management, described the program and major teaching approaches, and presented preliminary evaluation findings. The program is based on the belief that case management in long-term care is an advanced role and that optimal preparation for this area of practice is at the graduate level. Moreover, the program is based on the belief that advanced practice in long-term care involves not only clinical proficiency with clients and families, but also the ability to bring about change at the system level to improve health care and social services for vulnerable populations (Haw, 1995). The program is 36 units in length and designed to be completed in three semesters of part-time study. The program includes 18 units of core courses for all graduate students and 12 units specific to long-term care and case management. An additional six units of electives are required in a health related discipline. The three semesters coincide with three levels of courses. Because of the insufficient numbers of agencies and preceptors with expertise in case

management, students have had difficulty focusing their clinical especially in areas that do not have case manager role models. Haw (1995) addressed how these problems were solved to improve the clinical experience. According to Haw (1995) the program had significant impact on case management and long-term care through advanced practice by program graduates, through the ongoing work of the students in clinical agencies, and through collaborative faculty-student-community efforts. The program's impact was evaluated by reviewing major student and faculty projects and research studies completed during the program that documented student and faculty service to health care agencies via clinical practice, and surveying graduates and the employers of graduates. She revealed that the preliminary analysis of program outcomes showed the majority of employed graduates are functioning in an advanced practice capacity in case management, care coordination, or program management/administration primarily in community-based settings.

Grau (1984) didn't necessarily believe case management needs to be taught in undergraduate nursing education. Except for classes in financial management, the case management process differs little from the nursing process (Grau, 1984). He expressed the need in any basic curriculum for critical analysis of the long-term care system, with special consideration of the structural incentives and disincentives that influence who gets care and the kind and quality of care he or she receives. Grau (1984) observed that most policy makers and practitioners agree that case management is not a profession, but a set of functions to be carried out by persons capable of doing so...for the client, the nature of the case manager's background is important. The background and preparation of the

nurse case manager influences the kind of direct care the client receives as well as other aspects of service delivery and monitoring (Grau, 1984).

Davis (1996) stated nurses can develop the competencies needed by nurse case managers through staff development efforts that focus on education, practice, and peer review. She presented a framework for identifying the needed nurse case manager competencies and related role definition and required competencies needed to the defined population needs. Additionally, she stated the orientation process for nurse case managers should be built on the foundation of a theoretical framework, philosophy, and standards designed to meet the needs of the population served. Once the objectives of the case management service are clarified, then competencies can be identified. The Competency Based Orientation and Evaluation (CBO&E) program is then used annually to identify needs for the ongoing development of case managers. The educational process is an evolutionary one and should continue to be based on identified role expectations, identified learning needs, changes in client populations, and changes in payers. Davis (1996) stressed the need for a clear understanding of case management and differentiating the case manager role as it will be implemented in the particular institution as the overriding theme in any educational session. She included an outline for education case managers describing the content for seven lectures. The program content was designed for educating case managers at a specific institution including education on discharge planning, critical pathways, development and use, and financial aspects of case management as well as case manager roles, networking, and client education.

Stiller and Brown (1996) stated when implementing a case management educational

program, initially the focus should be on developing an in-house expert to lead the program. They suggested appointing this person is the least expensive way to prepare one individual to assume the role of in-house expert. The authors did not describe how the case manager expert was prepared for the case management role in the first place. Stiller and Brown (1996) did describe a step by step process for implementing case management, but there is little information offered about how to prepare nurses for their case management activities.

In Mayer, Madden, and Lawrenz's (1990) book, Zander preferred a BSN prepared nurse for nursing case management, but suggested these equivalencies in these areas could serve equally as well: (1) knowledge and use of the nursing process, (2) collaborative relationships with other nurses, physicians, and with patients and their families, (3) excellent management skills as shown by management of self, shift change responsibilities and case loads.

Zander (1988) stated fundamental to nursing case management is the belief that the case management role is best filled by a clinician who has direct-care, hands-on relationship with the patient and family. Therefore, once primary nursing is established, the case management role is a natural, necessary transition. Zander (1988) implied historically nurses have been at the committed juncture between patient and institution, but have either not been skilled in management or not been given the information, tools, or authority to manage care beyond their own shifts. She cautioned there will be developmental challenges positioning nurses as case managers if primary nursing is not already in place. Hospital-based case management, although conceptually similar to

primary nursing, case management is more deliberative about planning for resource allocation and interdisciplinary collaboration. In her article about implementing managed care via nursing case management, she described the role and primary nurse elements of the nurse case manager in an acute care setting, but only lists under case management education: orientation, ongoing case supervision, and ongoing consultation resources.

According to Grau (1984), because of the increasing acute and chronic health care needs of the elderly in the mid-1970s, the case management role seemed better suited for the nurse than a social worker. He stated, although qualified to meet the health care needs of their elderly clients, nurses coordinating care for frail older persons required education and skills in areas of functional assessment, community assessment, service coordination, and advocacy. These case management skills as suggested by Grau are very similar to Zander's for nurses in an acute care setting.

According to Fralic (1992) a well-planned program is required to prepare the nurse case manager to support quality patient care, promote the effective use of resources, decrease the length of stay, and maximize reimbursement to the organization. Orientation outcomes include the clarification of the new role responsibilities, the acquisition of advanced clinical and financial knowledge, the integration of management skills into the role performance, and the acquisition of knowledge about the effects of clinical interventions on the cost of care (Fralic, 1992). She stressed the orientation experience for nurse case managers should include didactic and clinical components and provide a structured precepted experience. She suggested a blend of clinical, financial, and managerial topics in the orientation and continuing education programs and advised

seeking active involvement of the organization's chief financial officer and finance staff in the initial orientation and ongoing education of nurse case managers. The author did not recommend or present a specific educational framework or program to use for case management education, but did place importance on the financial management preparation be included in the education process.

Baney-Car and McCoy (1994) developed and implemented the University of California San Diego (UCSD) Home Health Training Program to train home care case managers and career alternatives to the medical center nursing staff. They developed the program in response to a shortage in home care case managers and the elimination of nursing staff positions at UCSD Medical Center. Eligibility for the training program was limited to the UCSD Medical Center RNs who have had at least one year of acute care experience. Participants who completed the training program may apply for case management positions at the UCSD Home Care without meeting hiring criteria of six months prior home care experience. The UCSD training program was a 12-week course with 16 hours of didactic and 24-32 hours of field experience. It was free and 26 hours of continuing education hours were awarded for completion. Instructors were administrative, clinical, and support staff from UCSD Home Care who are specialists in the areas taught. Selected clinical staff completed a four-hour training session to become a staff preceptor and is responsible for training and supervising the participant's field experience part of the program. To enable their assistance in the program, staff preceptors received credit for their trainees' productivity in the field. Course participants made home visits including admissions, follow-up, and supervisory, first jointly with

their staff preceptor, then alone. The participants had to also complete three case studies using established guidelines. Each case study was presented orally to a clinical team in the agency and then submitted to the course coordinators. The pilot session of the UCSD Home Health Care Training Program started on July 1, 1993. The authors make no mention of gatekeeping functions or fiscal management of resources as part of the training. The training for the preceptors and the participants both seemed too short and narrowly focused. The role did not seem to be a true case management position. Outcome information from this agency is needed to evaluate the program's impact.

According to Graham (1989), advances in technology, acuity, and incentives for cost containment have contributed to the growth of home health care. This growth has meant greater visibility for nurses who provide home health services and has also called attention to home health as a legitimate area of specialization for nurses. In response to these trends and future demands the faculty in the School of Nursing at the University of Virginia designed a new major in the master's degree program to prepare nurses as case managers to function in the home care environment. The program's design is consistent with the position statement published by the American Nurses' Association. In the program, case managers may assume responsibility for health assessment, planning care, delivery and coordination of care and other services to meet the needs of the client and family including direct care, or only part of the responsibility. There are four courses that make up the new home health major. One of these is clinically focused with emphasis on client-family assessment, skill development, health teaching, and coordination of services. The objective of the second course is an in depth knowledge of the health care

system including health policy, legislation, and health care financing. In addition to these two courses there are two home health practicums focusing on the role development of the case manager and the overall operation of the home health agency. At the time, Graham's (1989) classes of students had completed the home health care major and several employment opportunities for the graduates were included. It was interesting that not one graduate was working as a home health case manager as an immediate employment opportunity, since the article stated the University of Virginia designed a new major to prepare nurses as case managers to function in the current home health care environment.

Zander (1990) described the education and training of unit-based case managers at New England Medical Center Hospitals (NEMCH). This model of case management in an acute care setting differs from others in that the care giver staff nurse is the case manager. Zander provided a managed care skills checklist to outline the training needs and describes the ground rules for case management built on the chief assumptions (1) nursing is a business with products rather than a service, (2) staff nurses in the role of primary nurse or case manager are accountable for clinical outcomes for the patients in their case load, (3) nurses need to use the nursing process in a continuous loop of assessment, goal setting, initiative, skilled intervention to include collaborating, follow through, and active evaluation. All RNs at the New England Medical Center Hospitals must pass a DRG test during orientation. The nurses must attend three days of mandatory management training within their first year of employment. Once appointed to a group practice for case management, there are three more days of training required. Zander

(1990) stated although each institution would tailor its own curriculum there are many items common to all settings and case types. The goals of the curriculum at the NEMCH are to provide (1) a description of and rationale for case management, (2) advanced-level nursing process skills, (3) case type specific knowledge, (4) system-specific information, and (5) collaboration and team-building experiences (Zander, 1990). An outline of the topics covered in the three-day case management training curriculum included: definitions of case management and the group practice model, and a review of assessment skills. However, no financial management or gate keeping education was addressed. Zander (1990) explained the start-up expenses of implementing managed care and case management are mainly education and developmental costs. She further stated the beauty of the NEMCH model is that as it develops and the group practices mature, continual cost benefits, paired with quality improvements, and implied that although case management gives the nurse authority in the system, it required additional training. Collaborative practice is at the caregiver level. Since the staff nurses work through attending physicians, which, depending on the institution's medical organizational structure, may put them in the middle of conflict. Case management retains experienced, motivated nurses and encourages them to make institutional commitments. Group practice members are required to be off the unit one hour a week for team meetings and to negotiate a flexible schedule that accommodates the needs of their case managed patients as well as the unit. Zander described a smoother transition for case managed patients between units after much facilitation getting the group practice case management off the ground. There were less prejudicial feelings among units resulting in an easier transition

for patients between units and increased knowledge for nurses and physicians.

Tahan (1996) presented an acute care case management training program that can be adapted for preparing nurses to assume case manager roles. The program also provides a tool to evaluate the case manager's performance. He advised the content of the program could easily be applied to an academic setting. Tahan (1996) stated the amount of time designated for instruction is based on the scope of practice of the case manager, the required educational background, and the level of experience. If the case manager is not master's prepared, Tahan proposed detailed discussions of topics such as management, leadership, power, conflict resolution, decision making, problem solving, critical thinking, team building, running meetings, and communication skills should be the included at length in the curriculum. He advised if the nurse was prepared on the master's level, a quick review of these topics is appropriate. Tahan (1996) detailed the case manager's skills and tasks in the curriculum and the case manager job description. The curriculum outline presented by Tahan appears to be the most inclusive case management education and training program. He also offered a day to day overview of the topics to be covered in the case management curriculum. Tahan (1996) implied it is important to include an historical description of the various case management models, the subtle variations among these models, and an explanation of how they relate to the organization. He expressed that it is necessary to discuss the process of implementing case management from planning to evaluation, the relationship among the various members of the healthcare team, the disciplines in the model, and the impact of the nurse case manager role on patient care delivery needed to be included in the curriculum.

Further he stressed the significance of the concept of change and change theory and process in case management. Since case managers function as change agents, they must have the knowledge to facilitate change, particularly during the implementation phase of case management.

Tahan (1996) detailed the five-day curriculum and provides an explanation of the subject content to be discussed on a day to day basis. Another aspect of case management training as described by Tahan (1996) was mentoring of case managers. He stated the use of preceptorship to facilitate the orientation and development of new nurses is well documented. Tahan explained that no documentation has been found linking preceptorship to the training and development of case managers. However, the same concepts used for training staff nurses are appropriate for training case managers. The usual preceptorship is two weeks, but remains flexible based on the needs of the individual nurse case manager. Feedback is key to the experience to provide support, guidance, and suggestions and modifications as required.

Sinnen and Schifalagua (1996) stated advanced practitioners must be prepared to meet the demands of a new climate and environment for the delivery of nursing care. They explained the ideal curriculum must assist in the formation of leaders who will know their theory well and be able to transfer the theory into practice and education of health professionals should go beyond social, behavioral, and biological sciences to include a study of human systems, compassionate and technical knowledge of illness, finances, and longitudinal experiences. They offered these core components to prepare the Advanced Practice Nurse for the future:

1. The practice of nurse case management within integrated delivery systems
2. Climate creation
3. Systems theory
4. Change theory
5. Leadership
6. Ethics
7. Economics within health care including healthcare reform
8. Continuous quality improvement
9. Research
10. Dissemination of knowledge

Mateo, Newton, and Warner (1996) explained the education program for case managers needs to be extensive. They advised active involvement to the chief financial officer and finance staff in the initial orientation as well as ongoing education for nurse case managers. They suggested information about time management, priority setting, conflict resolution, and team building be included in the case management education program, and holding regularly scheduled group meetings for case managers to discuss issues, problem, and frustrations. They stated a structured method of providing widespread education on case management is to sponsor a regional conference providing case managers the opportunity to network with others doing case management. The authors provided elements of a case management outline for an educational program. The outline is very comprehensive excluding gatekeeping functions. But no plan to implement the educational program or the costs involved in such an extensive program is offered. They stressed an important strategy for operationalizing case management is to educate staff and patients and their families about the case management model. In addition, they described the transition of the staff nurse to a case manager role and concluded that unit staff sometimes do not perceive the case manager as having the authority and autonomy to enforce plans of care. The authors recommended defining the

role and responsibilities of the case manager to the staff to facilitate the transition toward a case manager role.

One of the barriers to quality care is the lack of understanding and ability to control the care delivery process (Olivas, Del Togno-Armanasco, Erickson, & Harter, 1989). The process of case management can improve quality care nursing care delivery models, modifications of primary or team nursing, have evolved in acute care settings and are often called case management programs. The staff nurses for these programs, in turn, are referred to as case managers. In other acute care settings, registered nurses, as care providers, closely monitor health care resources and patient lengths of stay and often follow-up with patients after discharge. These nurses are also called case managers. The nursing care model used in the hospital to provide patient care may include some of the characteristics of case management but should not be called case management. The objectives of nursing care delivery are to assess the patient, identify the nursing needs of the patient during hospitalization, and provide nursing care necessary until the patient is discharged (Lyon, 1993). Common nursing care delivery models include team nursing, primary nursing, modified primary nursing and managed-care models. There are three categories of case management prevalent in health care settings. These models include hospital-based case management, community-based case management, and case management programs that cross a continuum of care in the hospital and community settings (Lyon, 1993). A clear definition of case management is needed to increase communication and eliminate confusion of program purposes among health care providers and consumers. Direct patient care delivery in the acute care setting does not fit

the traditional definition of case management, and to use the term in acute care settings causes confusion (Lyon, 1993).

Empirical Literature

Rheaume, Frish, Smith, and Kennedy (1994) examined case management and its usefulness to Canadian community health service agencies. The authors studied the effect case management has on nurse-client relationships and nurse-colleague relationships and explored how nurses are using case management as a way to achieve professionalism. Their article is based on a literature review of case management for community dwelling elderly residents and interviews with 17 community-based nurses practicing as nurse case managers in Canada. More than half of the nurses interviewed were not actually designated case managers, however, all the nurses viewed themselves as case managers. The authors stated that although the literature described most professional relationships under case management as collaborative, there were several difficulties encountered. The researchers said that some studies report problems between hospital discharge planners and case managers in community-based settings. Several respondents in their study described difficulties with physician relationships at the beginning of their case management practice. According to the study, eventually the nurses obtained credibility with these physicians and established collaborative, supportive, working relationships. The authors explained that relationships with other health care workers can be troublesome if the case manager's role is not clearly understood. For instance, discharge planners felt that case management was job duplication, and were concerned that case management would supplant them (Rheaume,

et. al., 1994). Other nurses may also perceive duplication of their services by a case manager. The literature on case management according to this study and the interviews with their respondents indicated egalitarian collegial relationships are possible under case management. Rheaume, et. al. (1994) contended case management, whether practiced in the community setting or hospital, is not an extension of primary nursing.

Tahan (1993) stated case management programs vary in terms of the case manager's educational preparation and average numbers of years experience in nursing. A thorough role description and function can be concluded, but such descriptions and functions cannot be generalized or adopted to nursing case management practice because they lack empirical validation (Tahan, 1993). Tahan (1993) did a review of literature and developed the nurse case manager role and function tool (NCMRFT) to define the role of nurse case managers in acute care settings. A descriptive study was done to examine the content and validity of the tool. The NCMRFT consists of four parts: three of 69 scaled items and one of 4 multiple choice questions. The questionnaires were mailed to 30 contract people of nursing case management programs in 30 different nationwide health care institutions identified as having nursing case management programs as of January, 1992.

The expert panel finally consisted of 21 people who evaluated the NCMRFT tool. Data were analyzed using the content validity index (CVI), which is defined as the proportion of the frequency of 3 (agree) and 4 (strongly agree) ratings of each item, as rated by the expert panel, to the total number of ratings (Tahan, 1993). The author decided to evaluate the validity of the tool at a CVI of 0.75. The experts in the panel

rated the 69 items in terms of the item's degree of agreement with the expert's understanding of the case manager role description. The CVI results of the items ranged from 0.52 to 1.00 with a mean of 0.91. The mean CVI of the clinical, managerial, and financial/business dimensions were 0.91, 0.84, and 0.98 respectively (Tahan, 1993). Only two items demonstrated a CVI below 0.75, and 51 items reported a CVI of 0.90 or above (Tahan, 1993). A baccalaureate degree in nursing (BSN) was recommended by 40% of the raters in the expert panel as an entry level requirement for the nurse case manager; 24% preferred a master's degree in nursing or related field; 8% suggested a diploma in nursing; 20% recommended a BSN but preferred a master's degree if possible; and 8% favored either a diploma, BSN, or associate degree (Tahan, 1993). The author found the majority (60%) believe that a BSN is a reasonable entry level requirement for a nurse case manager. This information supported the ANA's recommendation. His studied showed almost 48% recommended that the nurse case manager have 4 to 6 years of nursing experience; 38% recommended 2 to 4 years; 4.8% recommended 0 to 2 years; and 9.6% suggested 1 year as the minimum needed experience. Referring to nursing knowledge and background, he found 61.9% did not have any preference between generalized or specialized nursing practice; 28.6% preferred specialized nursing; and 9.5% preferred generalized practice and suggested the higher the qualifications decided (i.e., level III clinical ladder, masters degree, and 5 years experience), the more the attached costs. Tahan (1993) submitted nurses in both service and education should continue studying the nurse case management role to form a generalized definition that can be incorporated into various case management models. Also, he recommended the nursing case

management concept (model as well as nurse's role) should be included in curricula used to prepare advanced nursing practitioners.

Connors (1992) conducted a quasi-experimental controlled study, with a post test design only, to assess the impact of the Nursing Assessment and Management of the Frail Elderly (NAMFE) continuing education program. The NAMFE was implemented at the University of Kansas School of Nursing to increase the statewide distribution of nurses prepared to perform case management. The NAMFE group consisted of 65 nurses who completed the program. The comparison group was comprised of 57 nurses whose backgrounds were similar to the NAMFE group. Data for the study came from two self-reported questionnaires: the Competency Behaviors of the Case Manager Inventory (CBCMI) and the Demographic/Biographic Questionnaire (D/BQ). CBCMI is a tool used to assess nurse's perceived ability to perform the required clinical behaviors associated with case management and perceived importance of the behaviors to clinical practice. The need and demand for case management skills in various practice settings was demonstrated by the fact that on the D/BQ, 68% of the comparison group stated they were using case management skills in their nursing practice. However, 78% reported that these skills were not taught in their basic nursing program and 79% reported they had not participated in a continuing education program designed to teach these skills (Connors, 1992). Those subjects who reported having some of these skills integrated through their basic nursing program had not received a specific course designed to teach case management. Ninety two per cent of the NAMFE group reported a positive effect of the program on their approach to patient care. Connors (1992) stated because the results of

the study demonstrate no significant difference in the use of case management skills between the NAMFE group and the comparison group, and no significant difference in the use of case management skills among practice settings for the NAMFE group, it can be hypothesized that perhaps the job market was requiring nurses to use these skills when, in fact, nurses were not adequately prepared to do so. She further reported that the results suggest that although nurses in a variety of settings are required to perform case management skills, they do not consider themselves prepared for the job (Connors, 1992). The results of Connors (1992) study demonstrated no significant differences in the frequency of the instrumental use of case management skills between the NAMFE group and the comparison group. But, there was a significant difference ($p < .0001$ level) in the perceived preparation for performance of these skills between the two groups (Connors, 1992). The course is no longer available at the University of Kansas School of Nursing, but is offered as an elective for senior nursing students and graduate students.

Chapter Summary

Upon examining the literature there was evidence nursing case management is much more than an extension of primary nursing. Further examination of some educational programs on case management currently in use demonstrate similarities in the content of their curricula. Current educational programs are mainly institution specific and clinically based. Education and training of nurse case managers must be addressed in a broader sense to provide a continuum of care for clients in our dramatically changing health care system. There is limited knowledge about the effectiveness of the various case management educational programs. Examining the preparation and training of unit-

based nurse case managers in acute-care settings in a qualitative study may contribute to the case management knowledge base, formal education, staff development programs, and clinical practice.

Chapter III describes the methodology proposed for this study. The discussion of methodology includes the design, data collection, procedure, protection of human subjects, data analysis plan and methodological rigor.

CHAPTER III

RESEARCH METHOD

Research is frequently viewed as a systematic process employed to answer questions (Fawcett & Downs, 1992). The purpose of this research was to contribute to the fundamental knowledge about the preparation and training of nurse case managers in acute care settings. The researcher's purpose was to describe the training and preparation perceived by unit-based nurse case managers in acute care settings for their case management role. The following sections describe the researcher's methodology used to study this phenomenon in its natural setting.

Methodology

Methodology is the framework meant to facilitate achieving the needed clarity about the preparation and training of nurse case managers in acute care settings while also illustrating how to organize a mass of interviews and observations into coherent categories and ultimately themes for the sake of knowledge.

Descriptive studies involve observation of a phenomenon in its natural setting (Fawcett & Downs, 1992). Data are gathered by participant or non-participant observation, as well as by open-ended interview schedules or questionnaires. The raw data gathered in a descriptive study may be qualitative and/or quantitative. Qualitative data may be analyzed by means of content analysis. This technique is used to sort data into a priori categories or into categories that emerge during the analysis (Fawcett & Downs, 1992).

A qualitative descriptive design was decided as logical and appropriate for this study. Typically, naturalist designs are selected when little is known about a phenomenon, to return to the phenomenon in its natural, naive state (Sandelowski, 1986). The immediate and long-term objectives of this study were to naively examine in-depth the preparation and training of nurse case managers and ultimately provide descriptions that may sensitize other researchers and practitioners to their meaning, and may serve as the foundation for model and theory development.

The purpose of this study was to disclose subjectively the actual preparation and training experiences of nurse case managers in acute care settings through in-depth interviews and then document the phenomenon. Subjectively means the way in which the nurses made sense of the preparation and training they received for their case management activities. In nursing, this concern with subjectivity is one with meanings or "sense making" in a situation (Munhall & Boyd, 1993). To understand the sense that an experience means to a person is to grasp something of that person's reality, to see what is true from his or her point of view. This qualitative descriptive study focused on the subjective meanings rather than the assumptions and facts about the preparation and training of nurse case managers alone.

Research Design

The research method, or the plan to collect and analyze data that will answer the research problem, is one element of design. In qualitative research, method is tentative to allow for ongoing decision making through interaction with research participants and the discovery of the unforeseen (Munhall & Boyd, 1993). Qualitative research is a

systematic, subjective approach used to describe life experiences and give them meaning (Burns & Grove, 1993). Evolving from the social sciences, qualitative research was a way to understand the unique, dynamic, and holistic nature of people.

Qualitative research methods include phenomenology, grounded theory, ethnography, historical, philosophical inquiry, critical social theory, and descriptive. These qualitative designs generally share the following features: (1) holistic approach to questions, with a recognition that human realities are complex, (2) focus is human experience, (3) research strategies generally feature sustained contact with people in settings where persons normally spend their time, (4) high level of researcher involvement with the participants; strategies of participant observation and in-depth interviews are often used and, (5) data produced provide descriptions; usually narrative, of people living through events and situations (Munhall & Boyd, 1993). Thus, qualitative research involves broadly stated questions about human experiences and realities, studied through sustained contact with people in their natural environments, and producing rich, descriptive data that help us understand their experiences (Munhall & Boyd, 1993). This understanding may, in turn, guide nursing practice and add to the body of knowledge in, for, and about nursing case management.

For this study, a descriptive design was chosen as a means to generate knowledge concerned with meaning and discovery. The purpose of descriptive research is the exploration and description of phenomena in situations as they happen naturally (Burns & Grove, 1993). This approach is used to generate new knowledge about concepts that have limited or no research. Using this method to gather data, researchers often use

interviews and unstructured observation to gain insights through discovering meanings. Unlike quantitative research in which the design is a fixed blueprint for a study, the design in qualitative research emerges or evolves as the study is conducted (Burns & Grove, 1993).

Data Collection Procedure

The major way in which a qualitative research seeks to understand the perceptions, feelings, and knowledge of people is through in-depth, intensive interviewing (Patton, 1990). Direct quotations are a basic source of raw data in qualitative research, revealing participant's depth of emotion, the ways they have organized their world, their thoughts about what is happening, their experiences, and their basic problems (Patton, 1990). Gathering responses from open-ended questions enables the researcher to understand and capture the meanings of other people without pre-determining those meanings through prior selection categories via a questionnaire. Open-ended responses permit one to understand the situation as seen by the participant.

Sociologist John Lafland (Patton, 1990) has suggested there are four people-oriented mandates in collecting qualitative data. First, the qualitative researcher must get close enough to people and the situation being studied to personally understand in-depth the details of the situation. Second, the researcher must aim at capturing what actually takes place and what people actually say: the perceived facts. Third, qualitative data must include a great deal of pure description of people, activities, interactions, and settings. Fourth, qualitative data must include direct quotations from people, both what they speak and what they write down (Patton, 1990).

The following are examples of the type of questions that were asked during the interviews in this study:

1. Can you describe your role as a unit-based nurse case manager?
2. From your previous education can you tell me what helped prepare you for your role as a nurse case manager?
3. Describe the training you received for your current role as a nurse case manager?
4. Tell me your perceptions of the quality of the preparation you received for your role as a nurse case manager?
5. How do you achieve a controlled balance between quality and cost?
6. Can you describe how case management is supported or not supported within your workplace environment?

The researcher asked the participants to describe their role as a unit-based case manager and about their typical case management activities on a normal work day as a basis for the type of education and training required for their case management job.

The qualitative data, in the form of words, was analyzed in terms of individual responses. Codes and categories were identified for sorting and organizing data. The data was organized into meaningful, individualized interpretations in an attempt to describe the preparation and training of nurse case managers. No attempts were made to influence or control the interaction between the nurse case managers and the researcher. The findings from this study were unique and not intended for generalization to nurse case managers in all settings.

Sample Selection

Open-ended interviews add depth, detail, and meaning at a very personal level of experience. The open-ended responses permit one to understand the world as seen by the participant (Patton, 1990). The sample for this study was a purposeful convenience sample of eight nurse case managers working in acute care settings. The sample was drawn from two metropolitan hospitals. The participants were all registered nurses with a knowledge of case management. Purposeful samples are selected according to the needs of the study (Morse, 1991).

The selection criterion for this sample was a nurse case manager who had been working in a case management role for at least one year. The nurses were not required to have a master's degree in nursing or related field. The sample consisted of eight nurse case managers.

In qualitative studies the sample size tends to be small because of the enormous amount of information generated. The smaller sample size allows the researcher to examine the concepts of the study more in-depth. Practical factors, such as the availability of subjects, limits on time for data collection, and the complexity of data collection with a single subject, are instrumental in determining the sample size (Burns & Grove, 1993).

The sample was selected with the assistance of the nursing case manager coordinator at each of the hospitals. The potential participants were introduced to the study via a telephone call and arrangements were made for a scheduled audio taped interview. Each

interview lasted approximately 45 minutes.

Setting

Pure description and quotations are the raw data of qualitative research (Patton, 1990). The purpose of the description is to take the reader into the setting. The data do not include judgments about whether what occurred was good or bad, appropriate or inappropriate, or any other interpretive judgments. The data simply describe what occurred. The nurse case managers discussed what they perceived the preparation and training to be and do for case management. The descriptions help them make explicit their own judgment criterion (Patton, 1990).

Supportive working relationships had already been established by the researcher with the nurse case management coordinators at each acute care setting. Approval for access into the acute care settings was received from the Hospital Research Review Committees in each acute care stetting and the nurse case management coordinator. The exact location for the data collection interviews was determined by the nurse case manager and was acceptable to the researcher as long as it is a quiet environment. The interviews were conducted within the acute care settings. Individual consent was received from the nurse case managers at the time and place of the interview.

Interview Process

In qualitative descriptive research the role of the researcher and the technique of data collection are considered to be best communicated through a one-to-one relationship. The primary data collection techniques used in this study was in-depth interviewing. Data were collected from semi-structured interviews using open-ended questions

designed by the researcher. Data collected from ambiguous descriptions of behaviors and/or events was recorded as field notes by the researcher at the end of each audio taped interview. The nurse case managers were interviewed once and the interviews were tape recorded and later transcribed. At the end of the interview the nurses were asked if they have any additional information to share with the researcher that was not discussed during the interview. The further comments made by the case managers were described and recorded as field notes by the researcher.

The management of data included management of information recorded on the audio tapes and field notes from the researcher's impression of the participant's behavior or any other situation at the time and further comments made by the case managers after the tape recorder was turned off. The researcher listened to the tape recordings immediately after the interview for tone of voice, inflection, and pauses of both the researcher and participant along with content. Anything that stood out as noteworthy was included in the field notes and later integrated into the transcriptions.

Verbatim transcriptions of the audio tape recordings were done by a professional transcriptionist. The transcriptions were then entered into "The Ethnograph" (Seidel, Kjolseth, & Clark, 1985) computer software program. The computer software program is designed to facilitate organization, coding, and searching of written text and is less-time-consuming than the traditional cut-and-paste approach to content analysis. After the transcribed interviews were printed out, the words were read line by line and coded reflecting the content of the raw data.

Protection of Human Subjects

The Colorado Multiple Institutional Review Board (COMIRB) and the Hospital Research Review Committees at two large urban hospitals approved the research proposal and consent form prepared for the nurse case managers prior to beginning data collection. Protection of human subjects was achieved through informed consent, anonymity, and confidentiality. Following a brief explanation of the purpose of the study, the nurse case managers were asked to sign a consent form. For anonymity purposes, no names of participants or hospitals were used in this thesis. Instead, each transcription was identified by a code number such as, 26, 37, and 46. The data was collected for research purposes only.

Confidentiality was maintained by informing the nurse case managers that at the end of the thesis process, all audio tapes would be destroyed.

Data Analysis

The data collected by qualitative methods may be voluminous. Data analysis is the process bringing order, structure, and meaning to the mass of collected data (Marshall & Rossman, 1995). Qualitative data analysis is a search for general statements about relationships among categories of data (Marshall & Rossman, 1995). Reading and rereading transcripts, notes, recalling observations and experiences, and listening to the tape recordings, was done to become very familiar with the data as it was collected.

Data analysis for this study consisted of organizing the data and generating categories and themes. Each phase of data analysis requires data reduction as the reams of collected data are brought into manageable chunks, and interpretation as the researcher gives

meaning and insight to the words and acts of the participants in the study (Marshall & Rossman, 1995). Organization of transcribed data, coding, selection of specific elements of the data for categories, and naming these categories reflected the meaning of the preparation and training for case management by nurse case managers. Marshall and Rossman (1985) state the categories should be internally consistent but distinct from one another. Categories should not overlap.

The coded data were entered into the computer software program, "The Ethnograph" (Seidel, Kjolseth, & Clark, 1985), to facilitate reducing the volumes of data acquired into meaningful categories. The categories were examined until themes emerged reflecting the findings from the study. These themes represented the meaning of the preparation and training of nurse case managers in acute care settings. The analytic process of generating categories, recurring ideas and language, themes and patterns of belief that link people and settings are ongoing throughout the analytic process (Marshall & Rossman, 1995).

Methodological Rigor

In qualitative research, the researcher is the instrument (Patton, 1990). Validity in qualitative methods, therefore, hinges to a great extent on the skill, competence, and rigor of the person doing the fieldwork (Patton, 1990). Lincoln and Guba (1985) demonstrated the methodological rigor of inquiry guided by the naturalistic paradigm. Rigor in any research is required to prevent error of either a constant or intermittent nature (Morse & Field, 1995). Trustworthiness is the qualitative approach to scientific rigor. The basic issue in relation to trustworthiness is simple: How can a researcher persuade his or her

audience (including self) that the findings of a study are worth paying attention to, worth taking account of (Lincoln & Guba, 1985)?

The four criterion for the evaluation of qualitative research as described by Lincoln and Guba (1985) are: (1) truth value, (2) applicability, (3) consistency, and (4) neutrality. The following discussion explains each of these criterion and describes how it was addressed to establish methodological rigor in this study.

Truth Value

Truth value is operationally defined by Lincoln and Guba (1985) as credibility. Credibility is used to demonstrate the study was done in such a manner as to insure the data was accurately identified and described (Marshall & Rossman, 1995). In qualitative research, one recognizes multiple realities, so the researcher's job is to report the perspectives of the participants as clearly as possible (Morse & Field, 1995). If the study is credible, the participants will be able to identify with the findings.

Five major techniques to operationalize credibility are presented by Lincoln and Guba (1985). Of those, prolonged engagement and member checks will be utilized in this study. Prolonged engagement involves investing sufficient time to achieve certain purposes such as, learning the "culture", testing for misinformation from self or the participants, and building trust (Lincoln & Guba, 1985).

To establish credibility each of the participants in this study was currently working in an acute care setting. All the nurse case managers participating in the study had been working in the role of case manager for at least one year. All of the participants were registered nurses. A total of eight, 45 minute interviews were conducted with nurse case

managers from several patient populations in two different acute care settings. In addition, this researcher has seventeen years of nursing experience in various patient care areas including critical care, medical-surgical, obstetrics and gynecology, neonatal intensive care, and emergency department.

The period of prolonged engagement is intended to provide an opportunity to gain trust from the participants. Repeated contacts with the nurse case management coordinators in each acute care setting facilitated the development of a trusting relationship. The case managers from the two acute care settings were introduced to the study by the nurse case management coordinators.

The study was presented to the nurse case managers by the researcher during their monthly case management meeting to reassure the nurse case managers of their confidences and anonymity would be honored; there was no hidden agenda; the interests of the case managers would be honored; and that the nurse case managers would have input into, and actually influence, the research process (Lincoln & Guba, 1985).

Additionally, the member checks technique was used to promote the credibility of this study. The member checks, whereby data, analysis, and findings are tested with participants from whom the data was originally collected, is the most crucial technique for establishing credibility (Lincoln & Guba, 1985). Both formal and informal, member checking is a continuous process. Upon completion of this study and approval by the graduate school faculty, copies of the research project will be shared with two of the

participants providing and opportunity to air their disagreements and criticisms of the reconstructions.

Applicability

The criterion of applicability parallels the concept of generalizability used by quantitative researchers. Applicability is used to determine whether the findings can be applied in other contexts or settings or with other groups (Morse & Field, 1995). In other words, do the findings "fit" into a context outside this study.

Findings from qualitative research are seldom generalized to a larger population, because the findings are ultimately about the specific interaction between the researcher and the participant in a particular setting. Findings from this research study are not intended to be generalized to all nurse case managers.

Lincoln and Guba (1985) suggest transferability instead of generalizability be used to evaluate applicability. In transferability, the burden of demonstrating the applicability of one set of findings to another context rests more with the researcher who would make that transfer than with the original researcher (Marshall & Rossman, 1995). The original researcher is responsible for providing sufficient descriptive data to make judgments for transferability. This study generated rich, descriptive data with depth about nurse case manager's preparation and training for their role as case manager and facilitated the ability to transfer findings to similar situations.

An additional strategic approach to enhancing a study's generalizability is triangulating multiple sources of data. Triangulation is the act of bringing more than one source of data to bear on a single point (Marshall & Rossman, 1995). Using various

patient caseloads from two different acute care settings will strengthened this study's usefulness for other settings.

Consistency

Consistency emphasizes whether the findings would be consistent if the research were replicated with the same participants or in a similar setting (Morse & Field, 1995). Considering the uniqueness of human interaction, variation in experience is to be expected as opposed to identical repetition.

Lincoln and Guba (1985) suggested that dependability or audibility be the appropriate measures of consistency and reliability in a qualitative design. Development of an audit trail to document the researcher's decisions, choices, and insights is important in order to report when and why changes occurred. The researcher's impressions were tape recorded or hand written as field notes with attention to date, time, and context.

Clearly documented data collection and management of this research allowed for auditability. Selected transcripts were presented to the committee chair for review and confirmation of interpretation, the extent to which the data had been accounted for, and all reasonable areas were explored.

Neutrality

The last criterion to establish rigor is neutrality, which is freedom from bias in the research procedures and results (Morse & Field, 1995). Lincoln and Guba (1985) use confirmability or objectivity as a measurement of neutrality in qualitative research. The issue is no longer the researcher's characteristics (objectivity) but the characteristics of the data: Are they or are they not confirmable (Lincoln & Guba, 1985)? The appropriate

qualitative criterion is that the data help confirm the general findings and lead to the implications of the study (Marshall & Rossman, 1995). The critical thinking involved in examining the interaction between the researcher and the data is referred to as reflexive thought (Burns & Grove, 1993). In qualitative research, this critical thinking leads to bracketing, which is used to help the researcher avoid misinterpreting the participant's perspective of the experience. As the researcher becomes aware of personal feelings, assumptions, and preconceptions; he puts them aside or "brackets" them.

A deliberate attempt was made to recognize biases and record them as field notes. The neutrality of the researcher was intended to facilitate openness and new insights for this study (Burns & Grove, 1993).

Chapter Summary

A convenience sample of eight nurse case managers from two acute care settings was used for this qualitative descriptive study. Protection of human rights was provided through informed consent, anonymity, and confidentiality. Data was generated through semi-structured interviews using open-ended questions. The data were collected via audio taped interviews and field notes and later transcribed. Data analysis included organization, coding, categorizing, and theme development. Resulting categories and themes reflected the preparation and training experiences of nurse case managers in acute care settings.

CHAPTER IV

RESEARCH FINDINGS

The purpose of this study was to describe the training and preparation perceived by unit-based nurse case managers in acute care settings for their case management role. The results of the study are reported in this chapter. The personal profiles of the case managers are presented followed by the emerging themes.

Personal Profile of the Case Managers

The final sample was a convenience sample of eight nurse case managers from two acute care settings. Six of the participants were unit-based nurse case managers who managed patients on a particular unit of the hospital. Two specialty-based nurse case managers managed a particular population of patients with the same illness. Eight interviews were completed with eight nurse case managers.

The demographic information of the sample of nurses was obtained during the personal interviews. Table 1. displays the personal profiles of the eight nurse case managers. All of the case managers were registered nurses with a minimum of one year experience as a case manager. Two of the nurses had greater than five years experience in case management activities. All of the nurses had at least ten years of clinical experience with the exception of one nurse whose entire seven years of nursing experience was in utilization review and case management.

All of the nurse case managers had a minimum of Bachelors of Science in Nursing (BSN). The nurse with nursing experience in only utilization review and case

management had a bachelors degree in anthropology and a masters degree in nursing.

The nurse case managers were from eight different specialty areas or units within each acute care setting. Each of the nurses considered the unit on which they case managed patients as their nursing specialty. The nurse from the Neonatal Intensive Care Unit had a Masters of Science in neonatal nursing with national certification in the clinical management of high-risk infants. The nurse case manager from the psychiatric unit had a Bachelor of Arts degree initially and later went back to school for her BSN. One case manager described her nursing specialty as Rehabilitation Case Management and was the only certified case manager in the sample. The specialty-based nurse case manager in cardiology had a Post Masters Nurse Practitioner Certification in Adult Health.

The nurse case manager from the Pediatric Medical/Surgical unit stated her expertise was in the growth and development of children. This nurse had the most education of all the case managers and is currently working on her Ph.D. in Nursing Education. The nurse case manager from the oncology unit also had a post-masters degree as an Adult Nurse Practitioner and was oncology certified. The unit-based case manager of the Pediatric Intensive Care Unit has a BSN and 15 years of clinical nursing experience. The other specialty-based nurse case manager of congestive heart failure and heart transplant patients had a post-masters degree as an Adult Nurse Practitioner and was a certified Critical Care Registered Nurse (CCRN).

During the interview each case manager was asked whether a nurse case manager should be a masters prepared nurse. Three of the nurse case managers preferred a

Table 1. Personal Profiles of the Nurse Case Managers

Case Manager	P1	P2	P3	P4	P5	P6	P7	P8
Basic Preparation	BSN	BSN	MSN	BSN	BSN	BSN	BSN	BSN
Years Nurse	14.5	10	7	14	16	11	15	16
Years Case Manager	1	1	7	3	2	1.5	1.5	2.5
Nursing Specialty	Neonatal CNS	Psyche	Rehab	Cardiac CNS	Peds Med-Surg	Oncology CNS	Peds ICU	CHF
Highest Degree	MS	BSN	MSN	Post Masters	MSN	Post Masters	BSN	Post Masters
Certification	High-Risk Newborn		Case Management	ANP		Oncology		Critical Care
Other Credentials		BA	BS	BA	MS	ANP		ANP

Abbreviations: BS: Bachelor of Science Degree BA: Bachelor of Art Degree
BSN: Bachelor of Science in Nursing MS: Master of Science Degree
MSN: Master of Science in Nursing ANP: Adult Nurse Practitioner

master's degree in nursing for the role. These nurses believed a masters prepared nurse had a broader knowledge base, better organizational skills, more confidence, and practiced in an advanced role.

Three of the case managers believed a BSN with a solid clinical background (sufficient amount of clinical experience) was adequate for case management activities.

These nurses suggested the amount of previous clinical experience necessary for a nurse case manager would have to be considered on an individual basis. One nurse case manager recommended a BSN, clinical experience, and additional classes in business management, planning and control, family dynamics, and interpersonal relations as the prerequisite for a nurse case manger. The nurse case manager with only nursing experience in utilization review and case management stated a social worker could case manage the patients on her rehabilitation unit without any difficulty. One nurse case manager did not state her preferred educational preparation for a nurse case manager.

Introduction to the Organization of Data

The forms of data collection were audio taped interviews and field notes. The data were collected by one investigator. For the purpose of introducing the study, the nurse case managers were contacted by telephone and at that time interview arrangements were made. In all cases, the interviews were conducted off the unit in a quiet area. The interviews lasted approximately 45 minutes. The investigator used an interview guideline but the questions were not adhered to rigidly. Each semi-structured interview began with open-ended questions which allowed the nurse case managers' responses to guide the majority of the interview. The responses elicited from the questions suggested additional questions for each subsequent interview. Field notes were kept on all the interviews. For example, as the interview concluded and the tape recorder was turned off many participants continued to discuss their perceptions of case management. These field notes supplemented the data collected during the interviews and added insight and understanding to the perceptions of the nurse case managers.

Organization of the Data

The first step in the analysis process was to reduce the data generated into a more manageable and organized form. Data reduction, refers to the process of selecting, focusing, simplifying, abstraction, and transforming the data that appears in the written-up field notes or transcriptions (Miles & Huberman, 1994). The audio tapes from the interviews were transcribed by a professional transcriptionist onto a word processor. Next, the information was entered into the computer software program, "The Ethnograph" (Seidel, Kjolseth, & Clark, 1985), to assist in the mechanical management of the data. The computer program numbered the lines of the transcript and the information was printed out. The data was read line by line and affixed with codes that reflected the content of the raw data. Codes were used to capture the meanings reflected on one or more lines of the transcripts. Codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled during the study (Miles & Huberman, 1994).

In the process of sorting and sifting through the information the data was analyzed into patterns and processes that fit together. The data found to "fit" together were assigned to a particular category using a trial-and-error method. Accordingly, categories were modified to establish a sense of order to the mass of data. The final set of categories were compared to identify relationships, similar phrases, distinct differences, and common sequences. Impressions about the interrelationships between the data and the developing grouped categories were recorded by the researcher. These memos, along with field notes helped the researcher compare and validate the findings while the analysis proceeded.

As the patterns and processes, commonalties and differences were isolated, code words were grouped into categories and were connected or linked together. Gradually from the linked categories themes emerged. These themes elaborated a small set of generalizations that covered the consistencies discerned in the data base about the preparation and training of nurse case managers. Themes were supported by the categories and are not mutually exclusive and do overlap each other.

The description of the preparation and training perceived by the nurse case managers for their case management activities was illustrated by three themes. The themes generated by this study were: (1) **Moving the Patient through the System by Creative Problem Solving**, (2) **Expertise in Clinical Practice is Key to Success for Nurse Case Management Role**, and (3) **Overcoming Specific Barriers to Achieve Expected Patient Outcomes**. The themes and categories are outlined in Table 2. The following overview briefly discusses the themes and categories of the study. A more complete description of the themes follows the overview.

Overview of Themes and Categories

The first theme, **Moving the Patient Through the System by Creative Problem Solving**, described the creative problem solving strategies used by the participants while advocating a continuum of care for their patients across settings and for an entire episode of illness. Additionally, perceptions of unit-based case management and specialty-based case management are discussed in relation to the transition of patients from the in-patient unit to the out-patient clinic setting. The categories within this theme were "Advocating for both the Patient and the Health Care System", "Managing a Continuum of Care", and

"Negotiating and Creative Problem Solving". "Advocating for both the Patient and the Health Care System" signified the nurse's commitment to appropriate, quality care for the patient and family within the health care delivery system. "Managing a Continuum of Care" expressed the nurse's desire to case manage their patients from admission, through discharge from the hospital into the community, and follow-up. "Negotiating and Creative Problem Solving" described the problem solving strategies implemented by the nurse case managers to negotiate access to appropriate health care in the most appropriate setting.

The second theme, **Expertise in Clinical Practice is Key to Success for Nurse Case Management Role**, stressed that expert clinical knowledge in a nursing specialty was essential to case management practice. The categories within this theme were "Essential Case Management Skills", "On-the-Job Training is Beneficial but not Key to Success", and "Magnitude of Educator Role of the Nurse Case Manager". "Essential Case Management Skills" communicated the participants' impressions about the educational needs and basic skills a nurse needs to fulfill a case management role. "On-the-Job Training is Beneficial but not Key to Success" distinguished the nurses' experiences educating themselves about nursing case management and managed care in their respective acute care setting. "Magnitude of Educator Role of the Nurse Case Manager" identified the importance of educating about managed care. Nurses had to assume the responsibility for teaching the staff nurses, physicians, and the patients about the realities of health care in a managed care environment.

The third theme, **Overcoming Specific Barriers to Achieve Expected Patient**

Table 2. Themes with Supporting Categories

I. Moving the Patient Through the System by Creative Problem Solving

- A. Advocating for both the Patient and the Health Care System
- B. Managing a Continuum of Care
- C. Negotiating and Creative Problem Solving

II. Expertise in Clinical Practice is Key to Success for Nurse Case Manager Role

- A. Essential Case Management Skills
- B. On-the-Job Training is Beneficial but not Key to Success
- C. Magnitude of Educator Role of the Nurse Case Manager

III. Overcoming Barriers to Achieve Expected Patient Outcomes

- A. Systems: Hospital Practice Environment and Insurance Companies
- B. Health Care Providers: Physicians and Staff Nurses
- C. Facilitating Positive Patient Outcomes

Outcomes, identified problems the nurses encountered with the hospital practice environment, staff nurses, physicians and insurance companies. In addition, within this theme the nurse case managers explained efforts to overcome these barriers while trying to coordinate and facilitate efficient and effective patient care. The categories under this theme were, "Systems: Hospital Practice Environment and Insurance Companies", "Health Care Providers: Physicians and Staff Nurses", and "Facilitating Positive Patient Outcomes". "Systems: Hospital Practice Environment and Insurance Companies" described the nurses' continuous problems with hospitals and insurance companies while

trying to achieve positive patient outcomes and moving patients forward through the system. "Health Care Providers: Physicians and Staff Nurses" described the lack of education and understanding about managed care among physicians and staff nurses. "Facilitating Patient Outcomes", described the nurses' attempts to provide timely, quality, cost-effective and appropriate health care to patients for an entire episode of illness. At the close of each interview, the nurse case managers presented advice and recommendations for nurses considering a case management position in an acute care setting. The recommendations are discussed at the end of this chapter.

Themes

Moving the Patient Through the System by Creative Problem Solving

The theme, **Moving the Patient Through the System by Creative Problem Solving**, describes creative solutions implemented by the nurses to expedite tests, utilize hospital resources appropriately, and facilitate their patient's transition along a continuum of care and across settings for an entire episode of illness. The following categories represented the overall theme: (1) Advocating for both the Patient and the Health Care System, (2) Managing a Continuum of Care, and (3) Negotiating and Creative Problem Solving.

Advocating for both the Patient and the Health Care System. Advocating for the patient and the hospital explained the dual role of the nurse case managers providing loyalty both to their specialized patient group and their employer. The nurse case managers functioned as a consultant and as a liaison between the patient and the health care system. The nurses advocated for their patients by helping them solve their problems in a well developed case management plan of care. One nurse case manager

described how she advocated for the patient and the hospital with the following response:

> Well, it's multi-faceted, it's to work with all of the disciplines to come up with a plan of care for the patient while they're in-patient. Stick to that plan of care as closely as possible. Get them discharged to the best setting for them as soon as possible. Keep in mind the third party payer aspect of it. Being the liaison between the hospital and the third party payer. To give them the information that they need to make decisions on payment and what have you.
>
> I'll go through the unit and start working on kiddos that need to go home. For instance, this young man that I sent home on Friday. Start looking at him on Tuesday or Wednesday to see what had been set up, if a referral had started, and making phone calls. In this case to the Indian Reservation to see what kind of back up they had there. Getting social services involved if they needed to get involved. Do that type of thing for a good portion of my population. In between doing chart reviews and all of that, I'll be getting phone calls from home care wanting to know any kids that I think of on the unit that would need something that evening, or soon, so they can get started rolling.
>
> What's happening is the pendulum is swinging so payer based that we're forgetting the patient. We need to empower the patient, educate the patient so they can manage themselves well. That's what I see with some of the case managers who are very case management based. The unit-based in particular. We've everything all managed, the patient is going home...ta, da. That's it. What happens to the patient afterwards? And since they are not into the education, wouldn't even have the time to put into education, I think we need not lose sight of that. I guess, part of the whole thing with case management. My question would be are you managing insurance companies or are you managing patients.

The case managers collected information about their patient's health status and health care needs and made assessments to develop a case management plan of care. The case managers gathered information from patient rounds with physicians, medical record reviews, report from other nurses, talking to payer sources, and interaction with the patient and their family. The nurses reviewed their patient's vital signs, medications, lab tests, and results from other diagnostic procedures done in conjunction with an acute illness. The nurse case manager explained how they developed their plan of care in the following responses:

A typical day would be, first thing in the morning I come in and check to see if we had any new admissions. I will review their charts. I look up all the patients' labs, double check their medications, check vital signs, and if I have time I go in and just see how the patient did through the night. And about that time we have formal rounds at 9:30 where the interns and residents will present any new patients to the teams and then we discuss the old patients. It's at that time that's where we pretty much discuss any kind of issues, if they need social services or a visiting nurse, or if I know of any problems with insurance or finances they'd be brought up at that time.

You can get a pretty good idea when you review the charts where they're at, how close they are to discharge, what we're doing here that can't be done at home or in an alternate care setting.

I start with the new admits, you know, who they are, who their payer is, is the first question I have to ask. And most of this stuff I get from the chart and it's just from my clinical background in oncology. What things do I need to know? When did they last get their chemo. If the house staff admitted them, there is a nice little summary there, but it might not answer the questions we need answered. What kind of chemo did they get, when did they get it. So I review the charts and I'm looking for things like, um, labs. Do they have labs ordered? Do they have too many labs ordered? Do they have not enough labs ordered? When I look at meds I can look at why are they on IV. Can't they take PO?

I'm generally the only nurse on rounds, so I try to use my nursing judgment and think about nursing issues that haven't been addressed. Or if I've listened to report in the morning, I will say well this is what the nurses were concerned with overnight.

I usually do rounds by myself. I go around to the bedside and I take a data check on where the babies are at, their weight, whether they're nipple feeding or tube feeding, or NPO. If they're on the ventilator and what kind of oxygen they're on. If they're in an isolette. They're payer source and anything else that is going on. If they're under phototherapy. If they're having apnea or bradycardia. Just a big picture of what's going on on the whole unit. If there were any new admissions overnight I collect more intense data on that baby. I check the computer to see what they're payer source is and notify the payer.

I'll do the chart reviews which depending on my census can be pretty time consuming because it can take up to two to three hours to just go through and review charts and look at the history and physical to see why the kiddo is here.

Evaluation was the feedback mechanism for judging the quality of the care provided

compared to the standards for that care. The nurses reported both monitoring and evaluating the appropriateness and effectiveness of the plan of care for their case managed patients. Forms of monitoring and evaluation were checking lab test results, making decisions about home health care needs, examining the patient's financial resources for health care, monitoring length of stay and utilization of resources. One nurse case manager gave the following examples of monitoring and evaluation:

> I look at resources. Evaluate the patient's family situation, home situation so I can decide whether or not this patient is going to need visiting nurses or physical therapy at home. What kinds of resources do they have to pay for those kinds of services. Do they need IV antibiotics or IV inotropics. We send some of our patients home on IV Dobutamine and consequently I need to make sure that the nursing service that will be provided in the community is capable of providing those services. I work with our heart failure clinic to make sure that follow-up is done very closely on these patients and make sure the appointments are kept up with. I often see the patients in clinic or visit with them in clinic to make sure things are going O.K. I serve as a resource so that when those patients get home. If they've not been to heart failure clinic, they call me to help make sure that things are going all right.
>
> I have a patient, right, this morning who overdosed on his medication. He's not in the ER right now because I've been able to manage him as an out-patient. That's the kind of cost savings and quality that I think you can do in a role like this. But because I have access to rapid out-patient evaluation by nursing and physicians you can control costs really, really, well. An individual was sent home with an ostomy, and the nurses were handing him four by fours and all these other supplies off the unit that are going to be counted against the hospital and not reimbursed. I was able to curtail that and direct the patient as to where to get his supplies and take care of that for him. Making sure patients are getting the appropriate follow-up, I think curtails costs. If you have someone who's discharged on Coumadin and they're not going to be seen for two weeks, and their Pro-time is not going to be followed. You're going to have him in the ER bleeding. By being able to manage them out-patient wise helps to prevent readmission and ER admissions as well. I think that's a quality of care that people forget.

The above participant was describing the results of monitoring and evaluating a plan of care through utilization of resources and follow-up which produced, not just cost

savings, but also quality health care.

Managing a Continuum of Care. The case managers presented a desire for continuity of care for their patients as they transitioned along the continuum of care and across settings. One way the nurses managed a continuum of care was through discharge planning. The nurse case managers explained adequate patient teaching about self-care, medications, and when to call the doctor, as one of their responsibilities for a safe, timely discharge. Discharge planning also included making follow-up appointments, arranging resources for home care, ordering and scheduling follow-up tests, writing discharge instructions, and reviewing prescriptions and discharge instructions. The nurse case managers reflected on discharge planning in the following responses:

> We're sending kids home so much sooner than we ever used to. There's so much more responsibility for education and discharge planning and getting the families prepared to take these kiddos home. And prepared to take care of them, not just get them out. It's to do it well.

> I don't make it to discharge planning rounds. That's where the discharge planner and the social workers get together with the house staff. But on my patient population, because I know them so well and pretty much have already interviewed them and know them. I already have a plan in place. So, I notify the visiting nurse if the patient is going to be discharged. And what needs to be followed-up on and coordinate with social services if they need to be transported to another facility for rehab or anything like that. I do the majority of the discharge teaching. I'm trying to get the nurses on the floors to do some but they don't do a whole lot of it anymore. They're very, very, busy.

> I sit down and review the patient instructions for home. It's kind of like I can summarize everything in my mind. Like what meds do they need, what's their follow-up, do they need more labs when they leave here, do they have the supplies they need, do they have some home care. I 'm reviewing all that then I can initiate it if it wasn't done. Like for our unit, a lot of people have gotten chemo and need a CBC in a certain amount of time. So, I'll go ahead and make their follow-up, before the physician recommends it. And I'll write it in the chart. They can change it if that's not what they were thinking. The house staff would have just said, Oh follow-up in a couple weeks. I've kind of directed them. No, they got chemo, they need follow-up in seven days for a CBC. Supplies for central lines. I

> go and interview the patient and ask do you have the supplies you need for your line. You're on this list of thirty meds, do you have any of these at home so we don't have to rewrite all these prescriptions. I leave the physicians cheat notes or I'll sit with them while they're writing up the discharge. I'll say they need this, they don't need that. Finding out where they can get their prescriptions filled, which in this day is hard. People can't get their prescriptions filled here, and that's most of our patients, if they don't have insurance. If they don't have a contract with their insurance company, I try to get a hold of their insurance and say well, where can they get them filled. Especially because we send people home on not so routine things.

The case managers' discharge plan for their patients facilitated access to care, provided standard of care, and promoted patient self-care and responsibility. All of the case managers realized a need for continuity of care for their case managed patients in the hospital and later as out-patients. One case manager stated:

> You admit to a particular team and once you're discharged you will probably never see those individuals again. You go to a different physician as an out-patient, so there is a big lack in communication.

A specialty-based nurse case manager described the way she provided continuity of care for her patients as they transitioned from in-patient to out-patient status as follows:

> How I'm doing it, in a specific patient population, there is a continuum of care because I work in the out-patient cardiology clinics so I see those patients in the clinic as well. And I work with those physicians in the out-patient arena so I can update them or inform them of certain patients that are coming to them by following up on tests and making sure they have the tests done.

The other specialty-based case manager stated providing continuity of care for her patients was one of her biggest accomplishments as a case manager. The case manager described the patients' reactions to specialty-based case management activities as follows:

> For them, when I walk into the clinic and they see me, it's like...Oh, thank God, somebody's here I know.

This nurse case manager realized the sense of security it gave her patients to know who

they can call if they have problems. In addition, the same nurse described the sense of security among the nurses and physicians in the out-patient clinic:

> They know, when a patient is discharged, that things are taken care of up until the time that the patient is seen in the clinic and that the patient knows how to access them and the patient is not lost in the clinic.

Another nurse implied her inability to provide continuity of care for her patients to her satisfaction with this response:

> If I had to compare myself maybe with someone on another unit, I think I'd have a lot better idea of what patients are doing. Because our patients are back and forth and back and forth all the time. I work closely with the out-patient persons in the sense that we talk on the phone a lot. I'll call them and they will call me. But, it's not satisfying enough for me. Our patients are ill only for this amount of time. Even if its two or three years, I think I could do a lot, I could embellish the role more if I had more contact with the out-patient persons. For instance, if you were on CT surgery, or something, and someone came in and had whatever they do, had a lung biopsy, and then left. Well, they're gone...they're probably gone for good.

This nurse meant she needed contact with patients from both the in-patient and out-patient areas to feel like she was providing continuity of care.

The nurses described themselves as either unit-based case managers or specialty-based case managers. Unit-based nurse case managers followed in-patients admitted on a particular floor or unit of the hospital. In contrast, specialty-based case managers followed a particular population both as in-patients admitted to the hospital and later see them as out-patients in the clinic for follow-up care. The unit-based nurse case managers were dedicated to a particular unit of patients with multidimensional health care problems. Whereas, the specialty-based case manager dealt with a specific population of patients all suffering from the same illness. One case manager explained:

> I think the nice thing about specialty-based is there's continuity from in-patient to out-patient and out-patient to in-patient versus just the unit where you see the patients while they're on the unit. Then once they are discharged, they're gone. I can follow up on them as an out-patient and make sure things are going fine.

When asked if they saw advantages to unit-based case management, the two specialty-based nurse case managers responded:

> Well, I'm biased. No, I don't. I think it should be some type of team-based case management versus unit-based case management. When you have ten different teams of physicians on one unit, like the one I worked, there would be just no way of knowing what was going on for that patient. I also think as a case manager of a specific population you can follow them for in-patient to out-patient. That's more important. By being the liaison, has prevented unnecessary admissions or gotten a patient in earlier when they weren't doing well. That's one of the biggest areas that was lacking before. There was just no connection between the two. I'm not fond of unit-based case management. Never have been.

> I see advantages for the institution. In that, the institutions can make sure that the insurance calls are made so insurance companies are happy and reimbursing the hospital. I see some advantages in that all patients have access to a case manager to help them even though many of them don't need case management. At least if there are needs they can be identified. So, I think that is helpful. There are some positives to it. My downside is when the patient leaves the door, it's not over. Unless you know what your follow-up is and those nurses or physicians are going to pick the ball up from the time they are discharged to the time they are seen in the clinic. It's not like in the community where your have one physician seeing the patient as an in-patient and that same physician seeing the patient as an out-patient. Here we don't have that.

The unit-based nurse case managers were also asked to explain the advantages of unit-based nurse case management. Responses from the nurses included the following:

> Just having a person that everyone knows as a case manager. They're a handy resource for the staff, easy to find, and the people get to know this is our case manager. I think it makes the whole education and communication process easier.

> You get a chance to develop a rapport with a set of physicians. You know your patient population so you know what to expect. You know your staff. It's easier to get cooperation from people you know. You know the strengths and weaknesses of the unit. It's a lot easier to do program development with a set, set of people. Versus specialty-based. I can actually see benefits to both, but a lot of

> kids are so multi-system that it's nice to know a little bit about everything so you can help pull the whole thing together.
>
> I don't think I do. I think it probably works less well than if I was specifically oncology based, in-patient and out-patient. There has to be an advantage for some units that is goes on. I guess you know the staff. I try to do a lot of work through the staff. For instance, here's what I'm thinking about Mrs. So and So, have you assessed this, have you ordered this. Or do you understand that this is her disease, and this is what the physicians are worried about, and she's leaving tomorrow, she needs these things. I try to do all that through the staff. Or most of that because I want them to be thinking that way. I shouldn't be the only one thinking about the next day.
>
> I think you know the big picture. I compare everything to rehab. You're the main person people will go to about anything. You are the trouble shooter. You can be the main person who knows everything and filter things out. I think that's important. It frees people up to do , like therapists, to do billable things. Whereas, I'm not billable. It's definitely worthwhile to have. It would be nice to follow the patients into the out-patient realm, which I don't do. That way you'd know for the whole continuum. That would be ideal to do the whole thing from start to finish. If there's one person to call, that they can call and then I can farm things out. I think it's incredibly advantageous.

The comments concerning the advantages of unit-based case management had some similarities. The specialty-based nurse case managers agreed they were providing better continuity of care for their patients from their admission to the hospital, through to discharge, and follow up in the clinic. The two specialty-based nurse case managers seemed satisfied with their patient outcomes.

The unit-based case managers said the advantage of knowing the staff on their unit helped them in their case management activities. However, they were dissatisfied with the lack of continuity of care into the out-patient arena of unit-based case management.

Negotiating and Creative Problem Solving. All of the nurse case managers were committed to appropriate, quality care for their patients and families. The case managers used a problem solving approach in their case management practice. They applied

creative solutions to problems interrupting appropriate, quality health care. The nurse case managers negotiated for access to care, utilization of resources, and unfragmented, nonduplicative, quality patient care through problem solving strategies. The following comments describe those solutions:

> Dealing with the families is a lot like finding out where they are at, what their needs are. Say the patient comes in and it's self-pay. I go to them and help them go through the financial counselors and come up with a payer source or financial plan. Just so you can take some of that burden of them or if you find out from their insurance that they are not going to pay for this test or whatever. To let the family know...just to keep them informed of what's going on.

> And then doing triage for, you know, we also work with several physicians in the out-patient arena. So if there are any questions they call us. And we spend, you know, I'll spend a great deal of time talking with patients on the phone. If they are having problems. Whether they need to come in? I'm following up on out-patient tests, or procedures, or labs. Looking those up. If they're abnormal, either contacting the patient or the physician. I usually order all the tests on the patients. So if they need any type of functional study, um, I'm usually ordering that.

> It's a lot more involved in rehab, because you're seeing the aftermath. Where it usually goes from here. Making sure that they're getting what they need and it's not costing them a lot of money. So, I do a lot more education on benefits on rehab. When we discharge patients to other facilities, I'm making sure it's within the network, if that's what they want. And this is a benefit and they understand their benefits. And explaining what Medicare is all about, even Medicaid. And then using some research to find creative funding from say durable medical equipment that isn't an option with certain carriers, going to trust funds, working with the social workers on that. So, rehab case management is much more involved than the other units.

> So, let's say we go on rounds and we've make a lot of decisions. A lot of times I have added input to that. Then I try to give the nurses an update of what we talked about, because sometimes the nurses and physicians are thinking on different planes about the same patient, about two real issues, but they haven't connected. So I run all that by the nurse and the charge nurse and give them updates.

One of the participants described how she intervened for an indigent patient who

needed five days of chemotherapy which was an out-patient regiment. The patient didn't want to go to the clinic for treatment because he didn't have the money for his co-pay. The patient would rather stay in the hospital.

I had to say no you can't.

CC: What about the doctors, what did they say?

This is a life-threatening disease that we can cure with chemo and he's staying here if he won't go to the clinic. I can see that as appropriate. I can see the hospital's side, and I can see the physician's side. If this guy doesn't get chemo, he's going to die. He has a disease we can cure with chemo and he's going to get that chemo if it means I have to keep him right her in this bed.

CC: They didn't think he had the money for the co-pay for the clinic.

That's what the patient tells us. So I say well we can't keep you here. But I also understand we don't want him to go home and not come back, because we're going to get sued, and this man is going to lose his life.

CC: So what did you do?

It was that obvious and blatant so I worked it out. The financial counselor really helped me. Or I would have called Admissions to ask what are we going to do about this. Let's do anything about this. Let's reduce his co-pay to the most nominal co-pay you can do or let's bill him for his co-pay so he doesn't have to pay it right now. We worked it out so he left that day and went to the clinic. They got his co-pay down to like three dollars a day.

Another case manager explained how she maintained continuity of care during the continuous turnover in Medical staff in a teaching hospital:

Our residents and interns rotate on and off services and a lot of times they will order daily EKGs, daily Chem 7s, daily CBCs, things that utilize resources that are not required by patients. Or they'll forget to order Pro-times on a patient we're loading with Coumadin. I try to make sure the appropriate tests are ordered or not ordered. I help manage those by collaborating with the physicians. I help with continuity of care in that, when a patient is admitted for the clinic I make sure the physicians on the in-patient side have got access to the out-patient charts, medications, recent tests and such. So that they don't have to repeat them. You don't have to repeat a treadmill if one was done two weeks ago.

Another nurse case manager reported maintaining continuity of care and good communication with this explanation:

> If I go through this list of patients I have right here in my pocket, I know that I'll see half of them again. I'll see three quarters of them again and I've probably already known half of them before they got here. So, I keep their profiles and I pull them out especially on rounds. Sometimes I can answer questions like when did they first get diagnosed, what chemo did they have back then. Things like that, I have it written down. I can pull that kind of information out. Say a patient comes back in and the house staff has changed. I can say well last Wednesday, she left against medical advice when we were treating her for pneumonia.
>
> CC: By house staff do you mean the residents and interns?
>
> Yes, because they change every thirty days.
>
> CC: Do you see the attendings every day or not?
>
> The attendings are here, but they're only here for thirty days. See, we have fourteen attendings, fourteen oncologists, who see patients at the clinic and one of them had to be the attending her during the month.

This nurse suggested keeping a written record of patient related events as a way to provide continuity of care in a teaching hospital where the physicians are rotating frequently on and off the unit.

To summarize, the theme, **Moving the Patient Through the System by Creative Problem Solving**, revealed how the nurse case managers utilized a problem solving approach to advocate for their patients and their employer, the hospital. The importance of delivering patient care along a continuum and across settings was realized by all the participants.

Three of the nurses proclaimed service-based case management was ideal because their patients would receive more continuity of care from in-patients to out-patients. Another nurse case manager saw unit-based case management as very advantageous, but

would prefer to follow her patients both as in-patients and as out-patients. One specialty-based case manager recognized the advantages of access to the out-patient clinic for quality, cost effective health care.

The two pediatric case managers agreed unit-based case management made education of the families and communication on the unit much easier. One pediatric case manager explained:

> Children's problems are so multidimensional that it's better to know a little about everything on the unit so you can help pull the whole thing together.

In all cases, the nurses were trying to bring their patient's entire episode of illness together and manage the patient totally along a continuum of care. All of the nurse case managers explained a desire to advocate for their case managed patients in both the in-patient and out-patient arena. The nurses agreed the patient comes first in their case management practice.

Expertise in Clinical Practice is Key to Success for Case Management Role

The theme, **Expertise in Clinical Practice is Key to Success for Case Management Role**, described how the nurses' expert clinical judgments determined efficient, cost-effective, quality patient care. The nurses used their clinical knowledge, professional skills, and training to provide case management. Expert clinical knowledge of disease management and care management are essential to the role of nurse case manager. Expertise in clinical practice of a specialized patient population produced appropriate nursing judgments, hence, quality patient care. Clinical expertise is the link between quality patient care and cost savings. Appropriate utilization of resources and cost savings are achieved from the provision of quality patient care by nurse case managers in

acute care settings.

Included in the theme were educational recommendations for nurses preparing for a job as nurse case manager in an acute care setting. This theme addressed the fundamental skills perceived by the participants as necessary to transition into a case management role. On-the-Job training for case management activities in an acute care setting was discussed as necessary but not the key to success for a nurse case management role. Additionally, this theme included the role of educator as one of the major role responsibilities of the case manager.

Two of the nurse case managers had previous experience with utilization review. One of the nurses, who saw herself as a pioneer of case management in her acute care setting, had intensive case management training with Karen Zander and Kathleen Bower at the New England Medical Center Hospitals in the late 1980s. This particular case manager initially began case management with her staff nurses as the charge nurse of a unit in the hospital. Since then her case management has evolved into a specialty-based case management role. The following categories suggested and lead to the overall theme: (1) Essential Case Management Skills, (2) On-the-Job Training is Beneficial but not Key to Success, and (3) Magnitude of Educator Role of the Nurse Case Manager.

Essential Case Management Skills. All of the nurse case managers' perceptions about the basic educational preparation needed and skills required for case management activities were based on at least one year's experience as a case manager. All of the nurses, except one, reported the clinical experience as the most important skill of a nurse

case manager. Most of the time the case managers relied on their clinical expertise to justify their plan of care and access to care for their patients to insurance companies. Realistically, the participants did not think a nurse right out of nursing school was ready for a case management role. The perceptions were those nurses wouldn't get the support from the physicians or the insurance companies to be able to get what they needed to take care of their patients. Once again, all of the participants, except one, felt that a social worker couldn't do the job they were doing with patients. In addition, without the clinical piece, the social workers wouldn't get the respect or support from the nursing staff. Since three of the participants had support and assistance form a social worker on their units, they had more time for patient and family education. When asked what skills are needed to be a case manager, the participants responded:

> I think a nurse case manager needs to have a fairly strong clinical background. I think that's the one reason I like specialty-based case management. The fact that I understand a transplant and heart failure makes it easier for me to make sure the patient is getting the appropriate care, appropriate tests. If I know a patient had a cath three years ago and had clean coronaries, the fact that this patient is coming in with chest pain it may not be ischemic. I understand the dynamics of all of that helps to guide care, when the house staff don't know this patient at all.

Further examples supporting clinical expertise included:

> I think if case management is here to stay, I think it would behoove nursing schools to implement case management in some of their curriculum. Never lose sight of the clinical part of it though. We can manage all the insurance companies we want. It's the patient that gets lost in that.

> I think when you are dealing with insurance companies and you are trying to justify why a patient needs to stay in the hospital you better know a particular lab may relate to their medical condition. If somebody's creatinine is bumping up, is that reflective of the medication versus somebody's worsening renal failure? You have to have a good pathophysiology background. When I had students the one's who really struggled were the ones who had very little clinical experience. They didn't know the medications. You have to be very comfortable with knowing

> what medications and what they're for and monitoring their labs making sure they coincide with the patient's condition.

These nurses recognized education in pathophysiology and pharmacology, in addition to clinical experience, as important in the preparation of nurse case managers.

The nurses thought a bachelors degree in nursing would be a good start for a case manager. The information gained in management classes and issues learned about community health from their BSN programs seemed helpful to the nurse case managers in their case management activities. One nurse said case managers incorporated the management process systematically through admitting a patient, developing a good case management plan, and being able to carry the plan through even after discharge. The management process she was describing could also be correlated with the problem solving approach of the nursing process.

One participant said her BSN program taught her to be holistic and to see the big picture. Other case managers coming from a Clinical Nurse Specialist role to case management reported their masters degree had broadened their knowledge base and given them the confidence to handle their case management role. One nurse suggested formal education giving an overall background in managed care, the legislation process, information about Medicare and Medicaid, and how health policy is generated would be helpful. Another participant gave her insight in the following dialogue:

> Case management needs to be taught in the curriculums of both BSN and MSN programs.
>
> CC: Do you think there should be a specialty area in case management or do you think it should be part of the curriculum?

> I don't know. I have this philosophy that the wheel turns. Were you around for primary nursing and the team nursing before that?
>
> CC: Yes, both.
>
> When you think about it, I'm not sure case management is going to last for more than another ten years and something else will come up. Hopefully primary nursing again. I'm not sure I would educate nurses to be totally case managers. My philosophy would be to educate damn good nurses and give them case management as an option. Just like you give them good basic levels of care. Nurses who can flex into anything and be good at what they do. I don't think I would recommend a curriculum of just case management, because I think in another ten years it's not going to be case management.

One nurse gave her perception of a need for a case management program in nursing school curriculums with this response:

> I'm afraid of what's happened with case management is that it's a buzzword. It's like managed care in that everybody's kind of coming up with their own version of it. This is an area where nursing could really make a difference. I think only through qualitative research, like you're doing, that we're really going to be able to find out whether there is this unified idea of what case management is. I think nursing schools could really make a difference if they could put together a really good case management program and train people to be case managers. But, I think there has to be a consensus and right now there really is no consensus among all the people out there. They're just doing their own thing. I think it looks good on paper but what's really happening out there in the real world. People are really losing sight of what case management is all about. I think we're going to lose a big opportunity again.

The above nurse case manager revealed her passion for nursing and was trying to express her desire for all nurses to take on the responsibility she had taken for quality patient care for everyone. She wanted answers and clarification to what was going on out there in the real world as she put it. She was frustrated with the vague areas of managed care and case management within our health care system. She wanted to make a difference. She believed nurses could be the answer to all the confusion and inconsistencies of the current managed care environment. And she wanted nursing to be part of the solution.

Additionally, classes in family counseling, conflict resolution, pathophysiology, pharmacology, anthropology, managed care, business management, and statistics were suggested by the participants to be included in nursing school curriculums. Most of these classes are already included in most baccalaureate nursing programs except for the business management classes and anthropology. However, most programs have a course in sociology as a requirement for a bachelors degree in nursing.

Assertiveness was a skill declared by the case managers as important to their role function. One nurse expressed herself as follows:

> I think a nurse case manager needs to have a good, strong clinical background. They have to be assertive. You have to be able to stand up and say: I don't think so guys. You have to be able to question without feeling insecure about and be able to take somebody talking back to you, saying: What do you know, you're only a nurse.

Confidence was another skill revealed by several of the nurses. Confidence is described in the following dialogue:

> CC: What are some of the skills, besides clinical experience, that a nurse case manager needs?
>
> I guess you need to work pretty independently. You can't be waiting for someone else to tell you what to do. You have to be kind of aggressive. As far as education, I'm not sure but I bet my masters degree as a Clinical Nurse Specialist really helped me prepare to be in a role like this. I don't think I would have felt like I could do that if I hadn't gone through the program.
>
> CC: Did your program give you confidence?
>
> I'm sure it gave me confidence. It certainly gave you ways to read research articles. I certainly not an expert at interpreting research but I can read them and it just maybe makes you question stuff. A masters degree makes you think differently.

Other skills necessary were suggested by one nurse as follows:

> I think they need management skills and some business sense, background in business management, and background in evaluation is helpful. I think you need good interpersonal skills and good mediation skills, and negotiation skills. Getting along with people. You just have to have a good clinical background so that you know your population and know how to talk intelligently to people.

Additional skills perceived as necessary for case managers included having good computer skills, communication skills, being flexible, having sensitivity to the needs of patients and families, and interpersonal skills.

On-the-Job Training is Essential but not Key to Success. Training meant the actual classes or orientation the nurse case managers had prior to beginning their case management activities. The nurses perceived their training for their case management job as insufficient. Most of their training in the acute care settings occurred on-the-job. The nurse case managers did attend institution specific educational programs designed to orient and train them in the role of nurse case manager. One of the nurses explained:

> I've sort of made it up as I went along. I don't know if...I'm sure there are things that I'm not seeing and maybe wouldn't still see if I had had all that training...things that I'm not seeing because I haven't had my mind opened to that yet.

In many instances there was no clear definition of the case management role for the participants because many of them were already in the job as the role and job description were being developed. Examples of the nurse case managers' job descriptions can be found in Appendix G. The role responsibilities of the nurse case manager which are outlined in their job descriptions are very similar to their actual perceptions of their role functions. One nurse believed she was initially hired because of her previous case management experience and was utilized as a resource for the other developing case managers in the hospital. Interpretation of the training by one case manager was:

> I don't think they didn't train me per se. I think it was that the whole program was developing and they didn't have a way to train.

She also mentioned during that time she had the assistance of a social worker who had been doing the case management for her unit.

Being at the right place at the right time was the impression of one case manger. This particular nurse expressed her appreciation with this comment:

> My role, probably like everyone else's role in this hospital was...I was here...and they found me something to do, which was nice. I mean I'm grateful for that. I'm glad they found me a job. I did mentor for a couple of days with other people who were in the role of case manager. But, they were my peers who were also Clinical Nurse Specialists and were also asked to be case managers. So, I'm not sure they knew any more than I did about what we were doing.

Four of the nurse participants described various forms of formal training they received other than meetings with the Quality Management Director. The case manager who started nursing case management in her hospital stated although her preparation had been experiential, she and another nurse were sent to a two day course in Boston, MA. The information on insurance and resource management they brought back from that course was basically implanted in the hospital. The same case manager explained after the hospital's case management group developed:

> They began classes every so often talking about what we're doing, how we're doing it, how we can do it better, and how to manage our stuff.

Another case manager remembered learning the concept of case management from an outside consultant who came for seven half day sessions. The nurse case manager described it as a mini course for people who were already started in case management. Training was illustrated by another nurse participant when she reported:

> We had a three day intensive major intensive training course. The rest of it was on the job. What those three days consisted of was we had the finance people talk about what the whole piece of it was. The whole was our different contracts, how we were paid, how we were reimbursed. So we got to know that piece of it. Then different insurance companies came and talked about what their expectations were. Social workers came and talked about how their role fits with our role. The people who came up with the plan described what they decided we needed and what their expectations were and went through the job description.
>
> CC: And is the training ongoing?
>
> It is. That's one of the purposes of our weekly meetings. Initially, when they were set up we'd have people come in and talk about the admission process. Home care agencies would come and talk about what they could provide so we knew who was a good referral and who wasn't. Since we've been doing it for a while we think we have that down. Now we need to know specifically how to deal with problem cases.
>
> CC: What do you feel was the quality of the training?
>
> It was beneficial. It wasn't enough. I didn't feel prepared to start my job.
>
> CC: Have you learned it on the job?
>
> Oh, yes.

A nurse from another institution said the case management educational program was not ongoing in her hospital and was done solely for the purpose of implementing unit-based case management.

All of the nurses attributed at least some of their training to weekly case management meetings which also included members of social services. One case manager explained the purpose of the weekly case management meetings in her hospital as follows:

> We have weekly meetings. That's where I've learned what the expectations were for the job. That you'll do X, Y, and Z. Those are the things we expect you to do. Then the education, they gave us the basics like what is managed care. It was done more in the role. We developed it as we went. The Director of Quality Management would be there every week with an agenda. Most of it was teaching for the first year.

When asked about the quality of the training received for case management, most of the nurses believed overall the institutions had done a good job. In one instance, the nurse case manager perceived the training for her role as poor. Another case manager discussed the quality of the training in the following dialogue:

> CC: What do you think of the quality of the training?
>
> I think it has been useful. It's been a lot of trial-by-error. I think it will be better now that they have it under their belt. When new case managers come in the orientation and education will be better. With us is was kind of hit-or-miss learning on my part. Things are much more structured so I think new case managers coming in will be much better prepared.

Other responses from the participants about their case management training included:

> It was a real quick week of mostly seminars. Listening to people talk about the vision of the hospital and how case management fit into that. That's the other piece. I don't think people knew what to teach or how to teach it. I think they worked hard at putting together the program. Some of it was valuable and a lot of it wasn't.
>
> I think half of my preparation came from my previous experience as a Clinical Nurse Specialist, at least half of it. The Quality Management Department gave me the tools I needed, such as their expectations. But we still really lack case presentations. I don't know what other people are doing. I don't know how anybody else's day compares to mine. I'm sure it's way different.

One participant suggested future training for new case managers should be done with a case manager preceptor.

Magnitude of Educator Role of the Nurse Case Manager. The education of staff nurses, physicians, patient and their families, and the insurance companies was a major role of the case managers. Although none of the nurses had previous education in managed care, they all recognized the need for formal education about managed care for every nurse. One nurse case manager explained:

> In our environment it's essential along with knowing what the third party payer's role is, because I don't think as health care professionals you want to think about it. But it has to affect your care in some way. Not the quality of care you give. Like what you can do and where you can do it. Education of families has to be your primary focus. Your patient comes first, of course. You have to have the families prepared.

Many of the nurses stressed the importance of patient and family education. They believed health care professionals had to acknowledge that managed care was affecting the way they delivered patient care. The nurse case managers implied patient education in self-care and family education about their loved one's care were the case manager's responsibility. In today's managed care environment, families are assuming more responsibility for patient care in the home.

One of the case managers stated you have to be willing to teach people such as, patients, families, insurance companies, and other health care professionals. Another nurse put it this way:

> You have to be able to explain to families what is going on in a language they can understand; and tell them what kinds of things to call us for. Nurses bring that which non nurses case managers cannot.

The following responses described patient and family education:

> I was a clinical nurse IV, as a staff RN and my specialty was ostomy care. Since that is so difficult to teach lots of people, I've kind of hung on to that for this unit. I still do a lot of the hands-on ostomy teaching for families. Plus I've stayed on the education committee for our unit, because that's such a big part of our role. Our role is education/quality control and I want input into the education.

> Most nurses have the ability to sit down with patients and families and talk and teach and I think that's what connects you with your patients. Not just walking in and saying, O.K. you have Medicare, you can only have a visiting nurse for three weeks, every other day, da-da-da and walking out. Instead of being able to help them understand what they need to do at home in terms of self-care. What kinds of things to call us for. Because the nurse will only be in for three weeks, every other day. Teaching them, which I think nurses bring that, that a non-nurse case manager cannot.

Patients also contributed to gaps in the continuity of care by not knowing or understanding their health care insurance coverage. Parents of children on Medicaid often weren't educated about their Medicaid benefits such as, what their responsibilities were and where to go for follow-up. One case manager explained the problem:

> What we often find is that the parents have not been educated about who their primary care provider is and where they're supposed to go for service. They'll come in and we'll treat them in the Emergency Room and then we have this hassle once they're admitted. And I'll have to send them over to DG. And they will say why do we have to do that. It's because they signed up for this type of Medicaid. They just don't understand.
>
> CC: That can get expensive.
>
> I'm thinking, if you're going to design a state system to try and manage people, at least educate the people. And it's not just the Medicaid population. A lot of people don't know what their insurance is. They have no clue what their coverage is. And that's really not my job. My job is to make them aware so they can be advocates for themselves.

The above nurse was explaining appropriate care in the appropriate setting and her job was to make patients aware of their responsibilities.

Occasionally the insurance companies or payer sources tried to bar or limit the delivery of quality patient care. In most instances, according to the case managers, the insurance companies' reluctance was from a lack of understanding or misinterpreting the health care needs of the patient. To overcome the ignorance of the payer sources the case managers would try to educate the insurance company about the patient's particular disease process. One case manager explained having to educate the insurance companies about a disease process to justify keeping a child in the hospital for treatment with the following account:

> I do a lot with pulmonary. Especially with Cystic Fibrosis. Some of the insurance companies will say this child doesn't need to be in the hospital; they can get their IV therapy through home care. Then I'll say, they do need to be in the hospital. Because if we don't get the mucus out of their airways, we're not going to get rid of the bacteria and the IV antibiotics are going to be wasted. Mucus clearance, the kind we do, is very aggressive. It has to be done by a professional respiratory therapist. There's no way that the family of a child with acute pneumonia can do that at home. So until we consider the child is stable, we want to keep the child here in the hospital so we can give the antibiotics and do the mucus clearance. A lot of times it means educating the case manager or medical director of an insurance company about how aggressive you have to be with Cystic Fibrosis for the quality of life of the child.

Lack of knowledge about managed care and case management activities by the staff nurses was noted by all the case managers. The nurse case managers taught the nursing staff about DRGs and Medicare, about empowering patients and families to help themselves, and about appropriate utilization of resources on their units. One case manager taught the staff nurses about DRGs and Medicare. Unfortunately, some of the staff nurses were too busy to learn about managed care because it was not their priority. Direct patient care was their priority. One case manager explained it this way to the staff nurses:

> Say they've been approved for a 1.7 length of stay, that means after 1.7 I don't get any more payment for this patient. So everything you're doing, the hospital is eating. If the hospital eats for too long, eventually they start cutting cost, and that means cutting nursing which means making your job harder. I think they understand that piece of it. They'll come to me and say this doc is doing this and I don't think that's right. What can I do?

The participant tried to get the nurses to apply and monitor the appropriate utilization of resources in patient care delivery. Later, the same participant said she believed the nursing staff was beginning to understand the constraints being put on health care and saw what she was doing to improve the quality of care.

One nurse case manager expressed frustration with the medical staff with the following response:

> You're kind of stuck between a rock and a hard place. They're still not wanting to change practice, especially in a teaching hospital. Getting them to not run a viral test for respiratory cultures, when it's not going to change how you practice. You just want the information, but it's not going to change what you do. Trying to educate them to not do this. And making sure there's always a plan of care documented. Getting surgeons to do that is like a major deal.

The case manager understood her responsibility to the institution to educate the physicians about practicing in a managed care environment. The above case manager was describing her logical effort to contain costs by discouraging tests just for the sake of information. The information received from the lab tests wouldn't have changed the plan of care. The case managers recognized their role in educating the physicians about utilization of resources and access to care in a managed care environment. The nurses educated the physicians about the aspects of managed care. For example, a patient was taken off the physician's service because he came through the Emergency Room and was in the wrong hospital according to the patient's insurance company.

Other times the nurses had to educate the physicians about why patients weren't supposed to stay in the hospital another day because of the patient's health care insurance coverage. Although the medical staff were learning from the case managers, all the nurses realized the physicians did not comprehend the dynamics of managed care.

In summary, the theme, **Expertise in Clinical Practice is Key to Success for Case Management Role**, supported the belief that nurses are ideal for case management based on their clinical expertise, formal education, and training. The most important skill for case management was clinical expertise in a nursing specialty. Nurses clinical expertise

in a specialized patient group is the link between quality and cost-effective health care. The nurse case managers offered suggestions for nursing education and specific classes that would be helpful for nurses preparing for a case management role.

All participants, except one, agreed a BSN was adequate for a case management role, however, some participants preferred a masters degree in nursing for the role. A case management specialty in nursing school was not advised by the nurses because they were uncertain about the use of nursing case management in acute care settings in the future.

"On-the-job-training" described the ways nurse case managers were trained for their jobs. The majority of the training was institution specific with the help of outside vendors and consultants in case management. There was one exception in which two nurses attended a case management training program outside the hospital. Those two nurses were considered the pioneers of case management at their particular hospital. On the job training explained how the majority of the nurses learned about their case management role.

The nurses learned case management activities either by evolving into case managers from a utilization review role, from social workers, and from specific classes on managed care and payer sources held at the hospital. Most of the case manager's training was from either their basic nursing preparation or education in advanced practice nursing.

Although the nurse case managers saw the training for their role as beneficial, it wasn't enough to prepare them for their new job. Initially, when the unit-based case management programs were started, most of the case managers learning occurred on the job through trial-and-error and hit-or-miss.

One major obstacle confronted by the nurse case managers was the lack of education about managed care among physicians, staff nurses, and patients and their families. All of the case managers realized the magnitude of their role as educator and made a constant effort to teach staff, patients, and families about the philosophy and process of managed care and case management.

The nurse case managers also educated the insurance companies about disease management to justify access to care and appropriate care in the appropriate setting. Each case manager asserted her number one priority was the patient and her goal was to deliver quality care resourcefully.

Overcoming Specific Barriers to Achieve Expected Patient Outcomes

The theme, **Overcoming Specific Barriers to Achieve Expected Patient Outcomes**, described examples of barriers encountered by the nurse case managers while working in acute care settings. Barriers were situations or problems which interrupted the delivery of timely, unfragmented, nonduplicative, cost-effective, and quality patient care. Specific barriers identified were the health care system and health care providers. The system was the hospital environment and the insurance companies. Health care providers included physicians and staff nurses.

Additionally, this theme described the nurse case managers' efforts to conquer some of those problems while trying to coordinate and facilitate efficient and effective patient care. The categories within this theme are: (1) Systems: Hospital Practice Environment and Insurance Companies, (2) Health Care Providers: Physicians and Staff Nurses, and (3) Facilitating Positive Patient Outcomes.

Systems: Hospital Practice Environment and Insurance Companies. Several systems problems within the acute care settings faced the nurse case managers while they were attempting to achieve desired patient outcomes and moving patients through the system. The hospital practice environment included the way the hospital provided patient care and treatments done in the hospital for the purpose of making a medical diagnosis and disease management. Insurance Companies are also considered part of the system. The nurse case managers reported not one of their case-managed patients was ever denied access to care by an insurance company. Often the case managers encountered a delay in patient care delivery due to waiting for a referral, nonavailability of an appointment, or a patient's lack of money for his co-pay. One nurse said:

> I've got a patient who's diabetic and having a glucose in the 600's but he can't get an appointment in the endocrine clinic for three weeks.

Later in the interview she explained:

> Cardio-thoracic surgery is a barrier. I've got a variance going in on surgery right now. They're too busy today. So they can't do surgery on a patient, although she's ready for surgery right now, until Monday. So the patient will sit here for three extra days. Those kind of things create more costs and its a barrier to good patient care. But I have no control over it. The system is the biggest barrier that we run up against. Patients who have no insurance take a phenomenal amount of work trying to get them lined up appropriately with their coverage, the appropriate clinics for follow up. Getting them into clinics is almost impossible.
>
> CC: How would you interpret the patient's knowledge of their insurance coverage?
>
> Very poor, Very poor.

A variance tool is used for documenting anything that interrupts the achievement of desired patient outcomes. The above case manager described an unacceptable delay in surgery due to nonavailability of an appointment. She also stressed the amount of work it

took to find access to care in the system for people with no insurance. One participant gave this example of how the insurance coverage affected patient care:

> Because what they do is look at a primary diagnosis. They put it in a computer system that gives them a diagnostic related group (DRG) with a length of stay. And that's the end of it. It's so cut and dried. If I ask what about all the organs involved in Cystic Fibrosis? They'll look at Cystic Fibrosis and they'll say pneumonia. And if the child comes in with pneumonia they won't realize with Cystic Fibrosis it's not pneumonia. It's a multi-system involvement and every other system can be affected by an acute pneumonia. But you can't tell what DRG it is and you can't tell the computer. Then you get paid this small amount from the state and then to go through the appeals process and everything. Half of the time they'll overturn it anyhow and their excuse is we know its outmoded and it doesn't work well but it's the best we have right now.

Access to medical records was regarded as a big problem for the nurse case managers. All of the nurse case managers said they traditionally did not have their patient's medical records readily available when they needed them which caused a delay in care. Many nurse case managers suggested computerized medical records would help expedite care and increase communication. One participant explained the situation as follows:

> We have hand written medical records. They're not here. We admitted two patients for chemo today. The intern and resident are begging us to get the old chart. We would if we could. It just hasn't arrived and it won't for hours.
>
> CC: Where is the old chart?
>
> Who knows. They're talking about letting me have access to things on my computer like dictation, their last clinic notes, scans, MRIs. Getting reports right off the computer. That would be fantastic because we have someone we just admitted with a new diagnosis of testicular cancer. We've never seen him before. He wasn't supposed to be admitted, but he had a complication and had to come in. We don't know where his disease is, what his disease is. We've never seen him before and we have no record of it. He was just supposed to go to the clinic today and get chemo. We're going to treat him but it will take hours to get all the information because none of us are going to treat him until we have that information. I'm supposed to be able to do all that on the computer.

Another participant discussed her problem with medical records in the following dialogue:

> CC: Do you have any problems getting the medical records?
>
> Yes, phenomenal problems in my patient population. We keep shadow charts on our patients.
>
> CC: What is a shadow chart?
>
> A shadow chart is a chart that's kept by the clinic itself on the patients. It's copies of notes, copies of studies that have been done. All of these records are in the medical records. Medical records is several blocks down the street. Trying to get them here sometimes is a bit of a problem especially if the patient was seen in renal clinic or endocrine clinic or somewhere else and the physician is holding onto the records because they need to dictate a note or something and then the patient gets admitted and you can't find the chart. By having the shadow chart you at least have some kind of basis. And that is what I provide for the physicians upstairs. So they can start of running, instead of stumbling.

The above nurse suggested shadow charts as a solution to not having the original chart immediately available for patient's who might have been just admitted for treatment on her unit. The process of copying medical records seemed risky to this investigator for several reasons. Certain tests results may not be in the record when the record is copied. A form with a note or test result could be labeled with the wrong patient's name and get filed incorrectly. A form may get missed when the record is copied. Another nurse explained her problem with medical records:

> The barrier, truly, that I see is not having medical records available. That has created unnecessary admissions, unnecessary delay in tests, or unnecessary tests altogether.

The same participant later in the discussion described further barriers to patient care:

> Getting tests ordered and getting consults when we request them are problems. Sometimes it will take one or two days before the consult service comes by and sees the patient. One of the biggest barriers we have is the large indigent population we have. There is such a lack of resources around like getting these

> people medications when they can't afford them. I work closely with some drug companies in getting sample medications for patients, because they can't afford them. Trying to get patients into the appropriate health care setting is sometimes a barrier because you have to get referrals for everything. Sometimes that slows down the process as well. You get a patient's lack to follow up because of that especially if you can't make an appointment for them. They run into just as many problems after they are discharged by calling and not able to make an appointment. Then they just give up.

The above case manager explained the difficulties she also encountered expediting tests and diagnoses, finding resources for the poor, and getting a follow up appointment. Each of these barriers affected the case manager's ability to move the patient through the system. On occasion, care would be held back while waiting for a referral number from the insurance company, the results of a consult, or simply a phone call back form an insurance company approving access to care.

Lack of a standardized tracking system to measure the cost savings and quality of care as a result of case management was communicated by one nurse case manager. She doubted any of the other case managers in her hospital saw tracking case management effectiveness as one of their priorities. Her frustration included a desire to see the evidence that case managers were making a difference in the cost and quality of patient care. The case manager expressed a fear of having to justify unit-based case management to avoid hospital staffing cuts. The case manager's anxiety was displayed in the following dialogue:

> CC: Do you have a specific role model you are following?
>
> I don't have one. I really don't know where we're going with case management at this hospital. I don't know because I don't have anyone setting standards for me and helping show me and there's no measurement of where we're at or where we want to be. There's no attempt to look at these issue and it's frustrating. I don't see how anyone can function without having a plan and then some way to evaluate whether they're on track or not. That's unusual for this hospital.

CC: Are you under Nursing Administration?

No, we're under Business and Finance. They've done traditional business management and that may be why we're not getting very far.

Case management activities are supposed to be monitored and evaluated for assessment of outcomes and appropriateness after care is delivered. Nurse case managers are expected to be accountable for their services and to evaluate the effectiveness of their activities.

Most of the case managers agreed a big problem affecting quality care was not being able to get tests done on the day that you need them because the system is overbooked. The case managers would then have to find a physician who could do the test in order to get it done that day. One case manager explained another barrier to good patient care caused by the system when cardio-thoracic surgery said they were too busy with this comment:

> Well, they were too busy today. They can't do surgery on a patient, although she's ready for surgery right now, until Monday. So the patient will sit here for three extra days. Those are the things that create more cost and is a barrier to good patient care.

Health Care Providers: Physicians and Nurses. Physicians and nurses often lacked knowledge and understanding about working in a managed care environment. Their lack of understanding caused duplicative, costly, and fragmented health care. The case manager would educate the health care providers to help coordinate and promote appropriate, quality, and cost-effective care. Communication with the medical staff was another problem faced by the nurse case managers.

One nurse related her role at times as the middle person between the patient, the

physician, and the payer source. She described her frustration:

> Getting people to call you back. For instance, this case I was telling you about on Friday with them wanting to send this child home. Doctors with an unrealistic expectation about home care and what discharge planning is all about. Them thinking that you can get a child back to Montana with multiple needs on a Friday afternoon, to a remote setting, with no back up personnel. Weekend discharges are a nightmare for complex patients. You have on-call people so you don't have anybody that truly knows what's going on. You have all that barrier.

This nurse case manager was reporting the lack of knowledge about discharge planning by the medical staff and her frustration with weekend personnel on call because continuity of care was interrupted. Many of the case managers were frustrated with the rotation of resident and intern physicians on and off their unit causing difficulties in communication and interruption to the continuity of care for their patients.

Several case managers reported communication with the physicians could be difficult. One nurse replied:

> They change every month. That's a barrier. Because just when I think I've got one group educated the next group comes on.

Another nurse described the break down in communication with physicians as one of the drawbacks of a teaching hospital. In particular, when a patient came through the Emergency Room. Her response included:

> Because in our hospital you don't follow a patient. I mean that the physicians don't. At private hospitals a physician will admit their patient and follow them in the hospital and then follow them as an out-patient. Well, that doesn't happen here. You admit to a particular team, and once you're discharged you will probably never see those individuals again. You go to a different physician as an out-patient. There's a big lack of communication.

The nurse compared communication and continuity of care between a private hospital and a teaching hospital in regard to medical follow up care. The case manager described a

lack of communication and a gap in continuity of care because in her teaching hospital the same doctor who admitted the patient didn't follow the patient through the course of his illness.

Another case manager shared how her staff nurses, at first, resisted her assistance with infant discharges and now ask for her help:

> CC: What about the nurses in your unit, do you have conflicts or problems with them?
>
> I do something called a Transition Plan. The social worker helps too. We sit down with the families when they're ready to go home. We tell them this is what happened to your baby while he was here, these are the diagnoses. Do you understand all that? This is what your baby is going to need when he goes home. How can we best accomplish that for you? And we make a plan. A few of the primary nurses were a little bit upset with me doing that. They thought is was redundant. So they sat in on a few of them and they were won over and now they ask for the Transition Plan for their babies.

The participant was describing getting the trust and support from the primary nurses. Since her role was new she had to educate the nurses about her case management responsibilities and explain how they were all working toward a safe discharge.

Facilitating Positive Patient Outcomes. Efforts were made by all nurse case managers to expedite tests, conserve resources, and facilitate their patient's move through the system. One nurse distributed a monthly case management newsletter to her staff to educate them on managed care. Creating shadow charts was another attempt to alleviate the problem of not having medical records readily available. Another case manager educated health care providers about a particular patient's insurance coverage by documenting the patient's payer information on his medical record so it would be available for anyone involved in his plan of care. Two nurse case managers shared what

they had done to help the system:

> The hospital is getting charged through vendors things they shouldn't be. I've implemented a lot of money saving things for the hospital. I work on the committees with discharge planning. Having discharges be more cost effective instead of handing out the whole warehouse of central supply to people. We've developed a committee that has streamlined the supplies getting handed out. I was also on a committee for discharge prescriptions. Before I came on board, they were just handing patients bags of drugs to go home with the charges for the prescriptions on the hospital bill. You don't get reimbursed for those kinds of things. That's stopped. I'm not taking all the credit for that. I think I've educated a lot of nurses and physicians about what case management is. And to utilize me for a resource. They're starting to ask questions.
>
> For instance, in the Level I Nursery we had a contract with a visiting nurse service that every baby would get visited when they went home. That was costing many thousands of dollars. When I took over my job, they asked me to figure out a way to make that less costly. So I figured a lot of people were getting visits that didn't want or need them. Some people were getting visits that had payer sources that would pay for those visits and in some cases other agencies would go visit for free. So I made an algorithm so that people look at those things instead of just automatically assigning Visiting Nurses Service to visit. We're down like 75% of our cash out. If I could get that kind of information in all areas that would be really helpful and how to keep trends.

The above case managers presented some solutions that ultimately saved thousands of dollars for the hospital. Those cost savings have a positive affect on hospital resources and manpower.

In summary, the theme, **Overcoming Specific Barriers to Achieve Expected Patient Outcomes**, described how hard the nurse case managers worked to withstand systems problems in acute care settings. All of the case managers spent a great deal of time emphasizing aspects of a managed care environment such as, length of stay, benefits, appropriate utilization of resources, and a well defined plan of care. All case managers asserted their number one priority was the patient and the goal was to deliver quality care resourcefully. Creative solutions made a difference in the delivery of quality patient care

and toward achieving positive patient outcomes. Positive patient outcomes occurred when the patient's ongoing health care concerns are continually addressed, they receive specialized care, and there is an ongoing relationship with a physician.

Recommendations from Nurse Case Managers. At the conclusion of each interview, the nurse case managers were asked to give recommendations for nurses transitioning into a case management role. Recommendations from the nurse case managers included:

> I would tell them to really look at the job description carefully.
>
> You're no better than anyone else. You're part of one big team that's working on a good admission and a safe discharge...and getting paid for it.
>
> Make rounds with your physicians and get to know your patients and what their abilities are. And find good relaxation techniques. It's going to get harder, not easier. Be politically active. Tell patients to be their own advocates with insurance companies.
>
> After rounding with the physicians, my rule of thumb is to go back and update the nursing staff so they know what the plan for today or tomorrow is.
>
> Practice first. Distance yourself from the job a little bit. It's real easy to take all this personally. Sometimes things are out of your hands. Know what your limits are so you don't get burned out. It's intensive. In this role you see more of the whole picture. Sometimes you feel there is little hope for some of these families with chronic needs. It can get pretty overwhelming. Ideally, you should be precepted by a case manager. I think it would be good for any student nurse to spend time with a case manager.
>
> I think case management or managed care in the health industry is getting a bum wrap because people are wanting to put too tight of restrictions on health care. But, if you can be creative in your solutions I think it can get done.

Chapter Summary

A qualitative descriptive design was used to describe subjectively the actual preparation and training experiences of nurse case managers in acute care settings for

their case management activities. The final sample consisted of six unit-based nurse case managers and two specialty-based nurse case managers from two different acute care settings.

Data were collected from eight nurses, using semi-structured audio taped interviews. The data generated were transcribed and later organized using the computer software program, "The Ethnograph", (Siedel, Kjolseth, & Clark, 1985). The data that "fit" together were assigned to a particular category. Three themes emerged from the final sets of grouped categories. The themes were: (1) **Moving the Patient Through the System by Creative Problem Solving**, (2) **Expertise in Clinical Practice is Key to Success for Nurse Case Manager Role**, and (3) **Overcoming Specific Barriers to Achieve Expected Patient Outcomes.**

The theme, **Moving the Patient Through the System by Creative Problem Solving**, described how the nurse case managers used a problem-solving approach to their case management practice. The case managers demonstrated using in-depth knowledge about a specialized group to perform expert clinical judgments while moving the patient through the health care system. The nurses acted as a liaison between their patients and the health care system. All of the participants explained their role as manager of a continuum of patient care for an entire episode of illness. Through negotiation and creative problem solving the nurse case managers were able to facilitate access to care, continuity in care, and quality health care for their case managed patients in the appropriate setting.

The theme, **Expertise in Clinical Practice is Key to Success for Nurse Case**

Management Role, described nurses are ideal for the role of case manager based on their expert clinical knowledge and experience. The nurse's knowledge base and patient care experience allowed her to assess quickly and efficiently problems. Clinical expertise was quoted as the essential skill needed by a nurse case manager to justify standard of care in the appropriate setting for her case-managed patients. In general, the nurse case managers were trained while their role and job description were being developed at their respective institutions. The majority of training for case management occurred on the job. All case managers realized the importance of educating patients and health care providers about the philosophy and process of managed care and case management. The case managers devoted a significant amount of time disseminating new knowledge, assessing and addressing both patients' and the staffs' educational needs. Educating staff was not limited to nursing staff, but included, medical staff, and insurance companies.

The theme, **Overcoming Specific Barriers to Achieve Expected Patient Outcomes**, described the nurses' creative attempts to solve problems with the system and health care providers that hindered patient care delivery. The case managers collaborated with the multi-disciplinary team for effective communication, timely, appropriate, and quality, cost-effective patient care. The nurses demonstrated resourcefulness by knowing the limits of their role, their patient population, the institution, and their own abilities. In addition, the importance of addressing the patient's ongoing health concerns, getting specialized care, and an ongoing relationship with physicians was recognized for achieving better outcomes of care. Finally, the participants gave recommendations for new case managers transitioning into a nurse case management role.

Chapter V includes a discussion of the results of the study, a comparison of the results to information in the literature, implications for nursing, and limitations of the study. Recommendations for future research are included in the implications for nursing.

CHAPTER V

DISCUSSION OF FINDINGS

Chapter V includes: (1) a brief review of the purpose, specific aims, method, and results of the study; (2) discussion of the literature; (3) implications for nursing; and (4) limitations of the study.

Review of Study and Findings

The purpose of this study was to describe the training and preparation perceived by unit-based nurse case managers in acute care settings for their case management role. The specific aims of the study were to (1) describe the preparation that helped the nurses transition into unit-based care managers in an acute-care setting, (2) describe how the nurse case managers were prepared to implement the goals of case management, (3) describe those aspects of the nurse case manager's practice environment that facilitate and/or are barriers to achieving expected patient outcomes, and (4) to generate nursing knowledge to enhance the education and preparation of nurse case managers.

A qualitative descriptive design using open-ended questions during semi-structured interviews provided the method for this study. The researcher audiotaped eight personal interviews with eight nurse case managers from two acute care settings. Data were generated from the nurses' responses in the audio taped interviews and supplemented with field notes. Coding, grouping, and categorization of the data provided the framework from which themes emerged. The themes and supporting categories are outlined:

I. Moving the Patient Through the System by Creative Problem Solving

   A. Advocating for both the Patient and the Health Care System
   B. Managing a Continuum of Care
   C. Negotiating and Creative Problem Solving

II. Expertise in Clinical Practice is Key to Success for Nurse Case Manager Role

   A. Essential Case Management Skills
   B. On-the Job Training is Beneficial but not Key to Success
   C. Magnitude of Educator Role of the Nurse Case Manager

III. Overcoming Barriers to Achieve Expected Patient Outcomes

   A. Systems: Hospital Practice Environment and Insurance Companies
   B. Health Care Providers: Physicians and Staff Nurses
   C. Facilitating Positive Patient Outcomes

The role of professional nurse case manager is rapidly evolving as an outgrowth of the need for cost-effective and high-quality care in an increasing complex health care system, The role definitions and case management functions are similar among the unit-based nurse case managers working in acute care settings. Specialty-based nurse case managers are more satisfied with continuity of care through an expanded case management role into the out-patient arena.

Nurse case managers in acute care settings are expected to advocate for their patients and the hospital institution. As case managers, the nurses utilize their clinical expertise to link appropriate quality care with cost-effective care alternatives throughout an entire episode of illness. However, quality patient care is their first priority. Using a problem solving approach nurse case managers maintain a continuum of care through creative patient-focused solutions. Nurse case managers are responsible for identifying patient problems, making nursing diagnoses, developing a case management care plan,

facilitating interventions, coordinating and collaborating with an multi-disciplinary health care team, and evaluating outcomes of the care provided. In the role of case manager, nurses are accountable for achieving positive patient outcomes within an appropriate length of stay, utilizing resources efficiently, and establishing the quality of care provided.

Clinical expertise is the key to success for case management practice. Nurses are ideal for case management functions because of their expert clinical knowledge, patient and family care experience, educational preparation, and their commitment to the connection between the patient and the health care institution.

The more educated and experienced nurse case managers are, the better able they are at "seeing the big picture" and making clinical and managerial decisions. Nurse case managers implement the nursing process and holistic philosophy from their baccalaureate nursing programs into their case management practice. There is no consensus about the standard preparation of nurse case managers. A baccalaureate degree in nursing with three years of appropriate clinical experience is the minimum preparation recommended by the American Nurses Association (1988). Clinical Nurse Specialists prefer a master's degree for case management preparation because it provides a broader knowledge base and advanced clinical expertise in a nursing specialty.

Training for the nurse case manager role is evolving and continues to be on-the-job and institution specific. The job description and training of nurse case managers in acute care settings reflects the individual institution's philosophy of nursing service, standards of care, financial status, and marketing position. The educational process of nurse case

managers should be based on identified role expectations, learning needs, the particular patient population, and the payer sources.

A knowledge deficit exists about managed care among health care providers in acute care settings. Nurse case managers have a major role in educating staff nurses, physicians, and patients and their families about access to care, length of stay, appropriate utilization of resources, and the appropriate setting for patient care delivery in a managed care environment. Additionally, nurse case managers teach insurance companies about disease management and patient care needs during an entire episode of illness. Information about managed care, health care payer sources, and community resources should be taught to nursing students so they will be better able to dictate their patient care and not have their professional practice dictated by an insurance company.

Most barriers to continuity of care faced by nurse case managers are specific to the institution where they practice. Systems problems within the hospital are the major causes of delays in access to care and the delivery of quality patient care.

Discussion of the Literature

"Nursing can rightfully lay claim to case management; after all, service coordination has been the hallmark of public health nursing since the turn of the century" (Faherty, 1990, p. 20). Case management is not a new concept however, the role of nurse case manager is both emerging and evolving. Bower (1992) stated hospitals are using nursing case management as a way to improve the quality of care, empower nurses, and facilitate the achievement of institutional cost-effectiveness. In this context, the role of the case manager is continually evolving and differentiating form the role of general clinicians

(Bower, 1992). Formal education and training for the role is also evolving. As such, there is no unified description of the nurse case manager role or the formal education and training required for the job.

A second review of the literature was done and no new information related to this study was found. The following discussion compares the results from this study to other similar information in the literature. The three themes will be discussed individually.

The theme, **Moving the Patient Through the System by Creative Problem Solving**, described the creative strategies used by the nurse case managers advocating for their patients and the hospital organization. The case managers had potential for conflict within the acute care setting and with the patient. By looking at the "big picture", assessing, and evaluating situations, the nurses could identify conflict management strategies and implement creative solutions. The nurse case manager's additional role as advocate was to promote good communication, informed decision making, and information sharing within the practice environment of an acute care setting. Cary (1990) described the characteristics of the case management role as the ability to act as advocate for the patient and the payer source in models relying on third-party payment. Managing a continuum of care to promote quality, cost-effective health care was realized by all the participants as their case management goal. Bower (1992) stated: "The ultimate goal of case management was to achieve planned care outcomes by brokering services across the health care continuum" (p. 3).

The American Nurses Association (1988) described the continuity, quality, and cost containment aspects of case management as follows: "A health care delivery process

whose goals are to provide quality health care, decrease fragmentation, enhance the client's quality of life, and contain costs."

Ethridge and Lamb (1989) explained: "The Professional Nurse Case Manager (PNCM) is responsible for assessment of patient and family, establishment of the nursing diagnosis, development of the nursing care plan, delegation of nursing care to associates, activation of interventions, coordination and collaboration with the interdisciplinary team and evaluation of outcomes" (p. 30).

The theme, **Expertise in Clinical Practice is Key to Success for Nurse Case Manager Role**, represented nurse case manager's clinical knowledge and experience with a specialized patient population was essential for the achievement of quality cost-effective care. Bower (1992) proclaimed: "Nurses practicing as case managers are positioned as links between the quality and cost-effective aspects of care" (p 2.). The participants in the study used expert clinical knowledge, good communication skills, negotiating skills, and good interpersonal relations in the role of advocating a continuum of care. Bower (1992) related in-depth knowledge of current advances in patient care needs across the continuum (such as home, inpatient, and rehabilitation care) as vital to case management practice.

Many authors recognize nurses as ideal for case management activities based on their clinical knowledge and patient care experience. Grau (1984) suggested nurses were ideal for the case management role in the long-term care of the elderly based on their knowledge of geriatric care and community health. Nursing case management can also be understood as a new clinical system in which nurses are using their previously

untapped knowledge and experience to help institutions revise the care delivered to case-managed patients across an entire episode of illness, to eliminate fragmentation of services, to pull together the interdisciplinary team to decrease the length of stay, and to ensure the achievement of clinical outcomes (Zander, 1990).

Included in this theme was the formal education and training received by the nurse case managers for their case management role. Grau (1984) stated: "Nurses need to understand the context of their practice in order to be effective managers" (p. 374). Similarly, the more education a nurse case manager has the better able she will be to make competent clinical and managerial decisions. The Case Management Society of America (CMSA) standards encourage a minimum of a baccalaureate degree or, in the case of a nurse, licensure and at least two years' experience in nursing (Newell, 1996). Training for nursing case management in acute care settings continues to be institution specific and on-the-job. Tahan (1993) explained: "Hospitals have developed their own role descriptions of the nurse case manager in ways that fit their needs, standards, policies, and procedures, and financial positions" (p.53). Tahan (1993) also mentioned these hospital case management role descriptions have not been based on research or the literature.

Brockopp, Porter, Kinnaird, and Silberman (1992) discussed the University Hospital, University of Kentucky's (UK) model of case management designed to allow expert clinical nurses influence quality, cost-effective care. The UK model used master's prepared nurses because they were believed to have skills in collaboration and consultation, clinical expertise, and knowledge of evaluation techniques. Brockopp,

Porter, Kinnaird, and Silberman (1992) described a specialty-based case management model in which the case managers defined patient care problems and then may have used critical pathways to evaluate the success of various problem solving techniques. The UK model used a continuous process of identification and resolution to problems related to patient care to maintain quality of care and increase cost savings for the hospital. According to Brockopp, Porter, Kinnaird, and Silberman (1992) the case managers relied on their clinical expertise, other health care providers, and administrators to identify potential patient care problems.

The role of educator was described as part of the case management job for the participants in this study. The nurse case managers had ongoing teaching responsibilities to the staff nurses, the physicians, and the insurance companies. Bower (1992) listed: "Teaching, counseling, and educational skills---focusing on patients/families, peers, and other members of the health care team" (p. 24) as on of the skills needed to be developed in a curriculum for new case managers.

The theme, **Overcoming Barriers to Achieve Expected Patient Outcomes**, described the roadblocks encountered and the solutions used by the nurse case managers in their attempt to maintain timely, unfragmented, nonduplicative, appropriate, quality, and cost-effective patient care delivery throughout an entire episode of care. Problems faced by the participants in this study were with the system and health care providers while trying to facilitate positive patient outcomes. According to Bower (1992) in the case management model, nurse case managers provide and coordinate their patient's care, they are attentive to opportunities for creating changes in the system and clinical practices

that will improve and streamline care. Bower (1992) stated: "The overall purpose of case management was to advocate for the patient through coordination of care, which reduced fragmentation, and ultimately costs" (p. 2.) The goals of case management are often achieved by preventing inappropriate hospitalization or delaying hospitalization in acute care settings (Bower, 1992).

Implications for Nursing

Knowledge gained from this study is significant to nursing practice. Several ideas are offered for consideration to enhance positive patient outcomes and a clearer understanding of the nurse case manager's role. The information discovered about the nurse case management role implied increased role autonomy and authority which may help decide who are the most competent gate keepers in an acute care setting. This section is divided up into four areas: (1) Educational Preparation for Nurse Case Managers, (2) Staff Development of Nurses, (3) Advancing an Area of Expert Practice, and (4) Research and Theory Development Needs.

Educational Preparation for Nurse Case Managers

The findings from this study may provide a better understanding about preparation and training of nurse case managers for nurse administrators and educators to help them identify the future needs of nurses working in a managed care environment. Nurse administrators may benefit from knowing the problems and barriers faced by nurse case managers when evaluating job satisfaction and recruiting new case managers. Information gained from this study may influence the job market by the creation of an expanded nursing role in acute care settings, thereby, increasing nursing satisfaction and

retention. Nurse educators many use the information generated about the preparation and training of case managers in redesigning nursing school curricula. Nursing students need to be educated about managed care and nursing case management to prepare them for their role as a patient advocate. All nurses should have a basic understanding of payer sources, health care reimbursement, and community resources available. Staff nurses in acute care settings require background knowledge about managed care so they can adequately educate patients, families, and uninformed hospital staff about case management.

Nurses are prepared in their basic nursing program to help their patients solve problems. Nurses have experience in processing, designing, implementing, and evaluating patient care delivery. The nurse case managers in this study believed that nurse case managers should be recruited from experienced BSN nurses or from masters prepared nurses who have a defined clinical specialty. The case managers in the study stressed that recruitment should be based on the unique qualities of an individual nurse.

Many institutions prefer advanced practice nurses for case management. Findings from this study suggested masters prepared nurses are more qualified for a case management role. Advanced Practice Nurses in a nursing specialty have been taught how to integrate nursing theory, clinical expertise, teaching, and research into their clinical practice. Nurse Practitioners and Clinical Nurse Specialists are well qualified to be case managers in acute care settings. The study provided evidence that Advanced Practice Nurses have a broader knowledge base, more clinical expertise, self-confidence, and are

able to practice autonomously. All these qualities are required of an effective nurse case manager.

Staff Development for Nurses

Hospital staff development programs could facilitate a new nurse's transition into case management by utilizing information collected from this study in their orientation programs. Knowledge about the nurse case management practice environment may benefit nurses beginning a case management role. The problems faced by the nurse case managers in this study and the nurses' creative solutions may assist new case managers to implement case management activities in their own institution.

There is very little research on preceptor programs for nurse case managers. This study supported preceptorship with a case manager for new nurses assuming the role until they were ready for their case management responsibilities. Nurse case managers should not have to learn their role on-the-job in a hit-or-miss situation. This study described the benefits gained from weekly case management debriefings. The case management coordinators from the acute care settings provided the agenda for weekly meetings attended by the nurse case managers to provide ongoing education, mutual support, shared resources, and case studies. For instance, a case management support group would provide an opportunity for venting frustrations and preventing "burn out" in such a demanding and responsible position.

Many physicians and nurses in the hospital did not have a true understanding of managed care. Professional nurses could be very effective in the delivery of timely, nonduplicative, unfragmented, quality, appropriate and cost-effective health care if they

were taught about the realities of providing and advocating for patient care in a managed care environment. With this knowledge, nurses would be able to dictate their own professional practice versus having their practice dictated by an insurance company. Without this knowledge and education, nurses are at risk of becoming cost containment agents instead of professional patient advocates.

Advancing an Area of Expert Practice

The results of this study included examples of skills necessary for successful nursing case management. Clinical expertise emerged as the most essential skill for effective nursing case management. Nurse case mangers need to be able to synthesize that information into a nursing diagnosis and case management plan. These nurses have to be able to make accurate assessments of specific lab test results, diagnostic procedures, and medication usage. Nurse case managers facilitate the plan of care through negotiating and problem solving skills and finally measure the effectiveness of the care delivered.

Clinical nursing expertise is gained from years of professional practice with a specialized patient population. Experienced clinical nurses combine their skills in patient care delivery and clinical knowledge to appropriately manage a patient population. These qualities of a nurse provided the basis for case management practice and the reason why nurses are ideal for nursing case management. The findings from this study implied that without clinical knowledge and expertise in a nursing specialty, it may be difficult for the nurse case managers to get support and trust from the multi-disciplinary health care team.

Nurse case managers could be the answer to quality and cost-effective health care

based on their expert clinical knowledge of a specialized patient group and experience providing holistic nursing care for patients and families. Nurses have always advocated for the patients within the philosophies of the hospital practice environment. Nursing leadership in case management is needed to empower nurses to fulfill their role as advocates of patient care during an entire episode of care and dedication to cost containment in the current health care system. Nursing leaders need to be proactive in health care legislation to promote the unique contributions nurses provide in health care reform.

Research and Theory Development Needs

This study may stimulate nursing research to evaluate the efficacy and effectiveness of nurse case managers in acute care settings. There is a lack of concrete information and tools to collect data about case management activities to prove the results of nurse case manager's shared dedication to the patient and the hospital. Evaluation tools and tracking methods need to be developed for case management activities so nurses can show evidence of positive patient outcomes cost-effectively. The utilization of Advanced Practice Nurses as case managers may not appear to be economically efficient unless through research and tracking methods these nurses can present their cost-efficacy coupled with positive patient outcomes.

Nursing case management, although not a new concept in nursing practice, continues to evolve. There exists no consensus in the literature about the definition of nursing case management, the role functions, core concepts, job description, educational preparation, training, curriculum, or standards of practice. Future research is needed to empirically

validate the concept of nursing case management.

Currently, there are several models of case management activities in different settings. Therefore, defining a nurse case manager role is difficult. Each institution is training their own case managers paralleled with their mission and philosophy. The perceptions of the nurse case managers in this study may clarify the confusion among nurses about their role functions compared to other nurse case managers working in acute care settings. Training for nurse case managers needs to be clearly outlined and ongoing. Training should prepare nurses for their role as defined in their job description.

Research measuring the knowledge gained from various case management training programs would help define the case management training needs of nurses enrolled in future programs. The information collected may assist in the development of a unified case management training program curriculum for case management certification. This research may also contribute to the implementation of Certified Nurse Case Managers in acute care settings based not only on their clinical expertise, but also knowledge in case management.

The expert clinician must be a theoretician (Peplau, 1965). The synthesis of theoretical and clinical knowledge produces a basis for clinical and managerial decision making. Nursing science development is crucial for professional practice. It is, therefore, important to the nursing profession for nurse case managers to align case management practice with nursing theory. Nursing case management models were developed from business management theory and concepts, not nursing. Nursing case management practice needs to be examined for a theoretical base. Is nursing case management practice

aligned with management theory, organizational theory, or a behavioral, and humanistic theory, or no theory? Future studies may uncover what theoretical perspective nurse case managers are using to guide their practice and lead to a clearer understanding of the case management role definition. Case management guided by nursing theory would help unify the role expectations for the nurse and the health care institution. Unity in case management practice would strengthen the evidence of effectiveness of nursing case managers and help justify reimbursement for professional nurse case management through insurance mechanisms.

Throughout the study many ideas for future nursing research surfaced. Replication of this study with nurse case managers from privately funded hospitals is recommended to strengthen the information compiled about the preparation and training of nurse case managers in acute care settings. The findings of a replicated study could be compared with this study's findings to validate the generated categories and theme development.

A study comparing the patient outcomes of unit-based case managers and specialty-based case managers could provide information to hospital administrators and nursing management about the more effective model of nursing case management. Information on patient outcomes would contribute to concerns about continuity of care issues.

Another study that would be useful to nursing, the health care institution, and the payer sources would be to be to examine what standards of care are used by nurse case mangers to measure quality. What are the criteria for quality care? Who defines quality of care? Who defines the standards of quality care?

Collecting data on the amount of cost savings gained from nursing case management

would be beneficial in securing the nurse case management role in acute care settings. In these times of cost containment, nursing needs to measure their effectiveness controlling costs as well as achieving positive patient outcomes to show their worth to the institution and the payer sources.

Limitations of the Study

Two public teaching hospitals were used as the setting for this study. Data collected from nurse case managers in private hospitals would have provided similarities and differences in case management activities and training between public and private institutions.

During the interview process the researcher discovered two of the eight participants were specialty-based nurse case managers and not unit-based case managers, as expected. The interviews with the specialty-based nurse case managers were not discarded since they were functioning as nurse case managers in an acute care setting. In addition, the researcher wanted to investigate the perceptions of the specialty-based nurse case managers for the purpose of gaining a different perspective about case management preparation and training.

The majority of nurse case mangers participating in the study were from adult patient care areas. There were two pediatric nurse case managers involved in the research. Conclusions drawn from the study may have been different if all the case managers represented the same patient population.

Chapter Summary

This study described the training and preparation of unit-based nurse case managers in acute care settings for their case management role. In this study nurse case managers explained subjectively their case management role functions and problem solving strategies, the essential skills of a nurse case manager, and their experiences being trained for the role of nurse case manager in an acute care setting. The nurse case managers shared a dual advocacy to the patient and to the hospital institution. Clinical expertise in a specialized patient group was decided as the most essential skill to achieve quality, cost-effective patient care. There was no consensus about the educational preparation for nurse case mangers. Case management training was institution specific and reflective of the institution's expectations for nurse case mangers. The nurse case managers had major role in education of patients, families, and hospital staff about the aspects of managed care in order to facilitate timely, unfragmented, appropriate, and quality patient care.

Nurse case managers may be the link between quality and cost-effective health care based on their clinical knowledge and expertise. Nurses know what patients and families need. Nurses have always advocated for their patients. Through formal education and case management training nurses could provide leadership in patient care delivery and monitor health care spending.

Further research in case management is crucial for theory based professional practice. Outcomes research is needed to prove the effectiveness of the nurse case manager in acute care settings. Studies about the nurse case management role would help clarify the definition of nursing case management.

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APPENDIX A

CONSENT FORM

Consent Form Approval

Allan Prochazka, MD/Victor Spitzer, Ph.D.
Co-Chair, COMIRB

12/17/96
Date

COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

SUBJECT CONSENT
9 December 1996

PROJECT TITLE: Preparation and Training of Nurse Case Managers: A Qualitative Descriptive Study

PROJECT DESCRIPTION

You are being asked to take part in a study to describe the preparation and training of unit-based nurse case managers for their case management role in an acute care setting. You are being asked to be in this study because you have been working as a unit-based nurse case manager in an acute care setting for one year.

PROCEDURES INVOLVED

If you agree to take part in this study, you will be asked during an interview to describe your preparation and training for your role as a unit-based nurse case manager. You will be interviewed only once and the interview will take approximately 30-60 minutes. The location of this interview will take place in a quiet location at the acute care setting where you work. With your permission, the interview will be tape recorded for data collection purposes.

DISCOMFORTS, RISKS, BENEFITS

There are no risks or benefits to you for participating in this study. Your participation is entirely voluntary and you may choose not to participate or to withdraw from the study at any time.

SOURCE OF FUNDING AND COSTS TO SUBJECT

There is no direct funding received for this study. Your participation in this study will involve no cost or payment to you.

*Initials*_____

INVITATION FOR QUESTIONS

Please feel at liberty to ask questions about any aspect of this research or this consent either now or in the future. You may direct your questions to Colleen Carmody at (303) 988-8925, or Dr. JoAnn Congdon, Ph.D., at (303) 315-4286.

CONFIDENTIALITY

Colleen Carmody will treat your identity anonymously and all information obtained will remain confidential. The information gathered in this study may be published in a nursing journal, but your identity will not be revealed. If you have any questions regarding your rights as a research participant, please call Vicky Starbuck, Secretary, of the COMIRB at (303) 315-7960.

The audiotaped interview will be written down by Colleen Carmody. During this study the cassette tapes and written information will be kept in a secure place under lock and key. When the study is completed the audiotape of your interview will be destroyed.

AUTHORIZATION

I have read this paper about the study or it was read to me. I know what will happen, both the possible good and bad (benefits and risks). I choose to participate in this study: I know I can stop being in the study at any time I choose. I will get a copy of this consent form (initial all pages of the consent form).

Signature:_____ Date:_____
subject

Consent form explained by:_____ Date:_____
signature

Investigator:_____ Date:_____

Initials_____

APPENDIX B

APPROVAL BY THE COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

Office of the COMIRB | Assurance # M-1494-01 | Participating Institutions

Room 1810C
Campus Box C-290
4200 East Ninth Avenue
Denver, Colorado 80262
(303)315-8081
FAX (303) 315-8540

The Children's Hospital
Colorado Prevention Center
Denver Health & Hospitals
University of Colorado Health Sciences Center
Department of Veterans Affairs Medical Center, Denver
University Hospital

TO: COLLEEN A. CARMODY BOX 11950 W. ALAMEDA AVE., LAKEWOOD, CO 80228 DATE: 12/17/96

FROM: COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

YOUR APPLICATION ENTITLED: PREPARATION AND TRAINING OF NURSE CASE MANAGERS: A QUALITATIVE DESCRIPTIVE STUDY

COMIRB PROTOCOL NUMBER -: 96-722

Has been unanimously approved by the COMIRB 12/17/96 which includes your **protocol and consent form/revised consent form.** The COMIRB will require a follow up on the status of this project within a 12 month period from the date of approval unless a restricted approval applies. If you have a restricted or high risk protocol, specific details will be spelled out with a special set of instructions. We shall send you a form to be completed to define the status of your project.

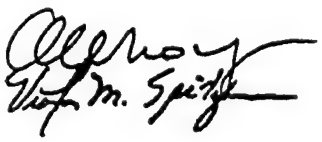
The investigator bears the responsibility for obtaining from all patients and subjects **"Informed Consent"** as approved by the COMIRB.

It is also your responsibility to **inform the COMIRB immediately** of any deaths, serious complications or other untoward effects of this research.

Please notify the COMIRB if you intend to change the experimental design in any way.

As of July 1, 1983, the COMIRB REQUIRES that the subject be given a copy of the consent form which includes the name and telephone number of the investigator.

Any questions about the COMIRB's action on this project should be referred to the Secretary Vicky Starbuck (315-8081 or UCHSC BOX C-290).



Allan V. Prochazka, M.D., M.Sc.
Victor M. Spitzer, Ph.D.
Co-Chairs
Colorado Multiple Institutional Review Board

Rev 9/96

APPENDIX C

INTERVIEW QUESTION GUIDE

I am going to ask you some questions about your preparation and training for your role as a nurse case manager.

1. Can you describe your role as a unit-based nurse case manager?
2. What are your case management activities on a typical work day?
3. How do you achieve a balance between quality care and cost?

1. What types of skills do you think are necessary for a nurse in a case management role?
2. From your previous education/experience, can you tell me what helped prepare you for your role as a case manager? Which classes were most helpful?
3. Would you describe the training you received for your current role as a unit-based nurse case manager?
4. Please tell me your perceptions of the quality of the training you received for your role as a nurse case manager.

1. What do you see as your major accomplishments as a nurse case manager?
2. Could you describe what you see are the advantages or disadvantages of unit-based nursing case management?
3. Can you describe how your role as a nurse case manager is supported within your workplace environment (unit or hospital)? Could you tell me about things that help you or are barriers that you face in patient care delivery, coordination of services, and achieving patient outcomes?
4. What advice do you want to give to new nurse case managers or someone considering a job as a nurse case manager? Do you have any recommendations about education?

APPENDIX D

EXAMPLES OF CODE WORDS

accomplish
barrier
clinexperi
communicat
expertcm
followup
negotiate
patpart
prevexperi
resourceut
specbcm
training
advice
broadpictu
computer
curriculum
hcresource
newjob
payorsourc
problem
quote
respect
staffeduca
transition
advocate
careplan
cmprep
consultant
discharge
facilitate
homecare
pateducat
pioneer
quality
rounds
stress
ubcm
assertive
class
collaborat
coodinate

APPENDIX E

EXAMPLE OF UNNUMBERED TRANSCRIPT

appointment - they just give up ...

CC: Oh.

46: ... so - we see a lot of that.

CC: You're - in a way - talking about quality of care issues - how do you see yourself balancing quality of care and cost - um - you know - cost savings - or - being cost effective in your role - you know - you were talking about - um - trying to get pharmaceutical samples - what are some of the other things you might do?

46: Well - I mean - I think that - you know - quality certainly comes before cost concerns - but úm - if - uh - if I'm faced with a patient being discharged - and they're on - um - for instance - often times we have a procedure where we have to put a stint in a patient's vessel - and they have to go home on two very expensive drugs for a month - and - for a month one of the medications costs about $120 - if it's an indigent person - there's no way they're going to be able to afford that - so I have - actually - on occasion - called the legal department and said - and discussed the case with them - because I - you know - here we've done a very expensive procedure on a patient - and we're are - I feel - obligated - to provide that patient with the necessary medication - so it doesn't clot off - and - usually - the hospital has been very flexible - and will say - we do have that legal responsibility - but part of that is - you know - trying to figure out if - truly - a patient can afford it or not - to begin with - um...

CC: So would that make a difference - if they couldn't afford the procedure - they might not get it?

46: No, no, no - no, no, no - they get it - they'll get it - it's just making sure - though - that after we do something - that we provide them with

APPENDIX F

EXAMPLE OF NUMBERED AND CODED TRANSCRIPT

Numbered Version of File 86.ETH 2/19/1997 15:25 Page 5

CC: Um hm. 222

86: ... you know - so I can follow-up 224
on - if I initiate Medicaid - um - 225
disability or Medicaid - as an in- 226
patient - I can follow-up on them as an 227
out-patient and make sure that things 228
are going fine - and do they need any - 229
does social services need anything else 230
- that kind of stuff. 231

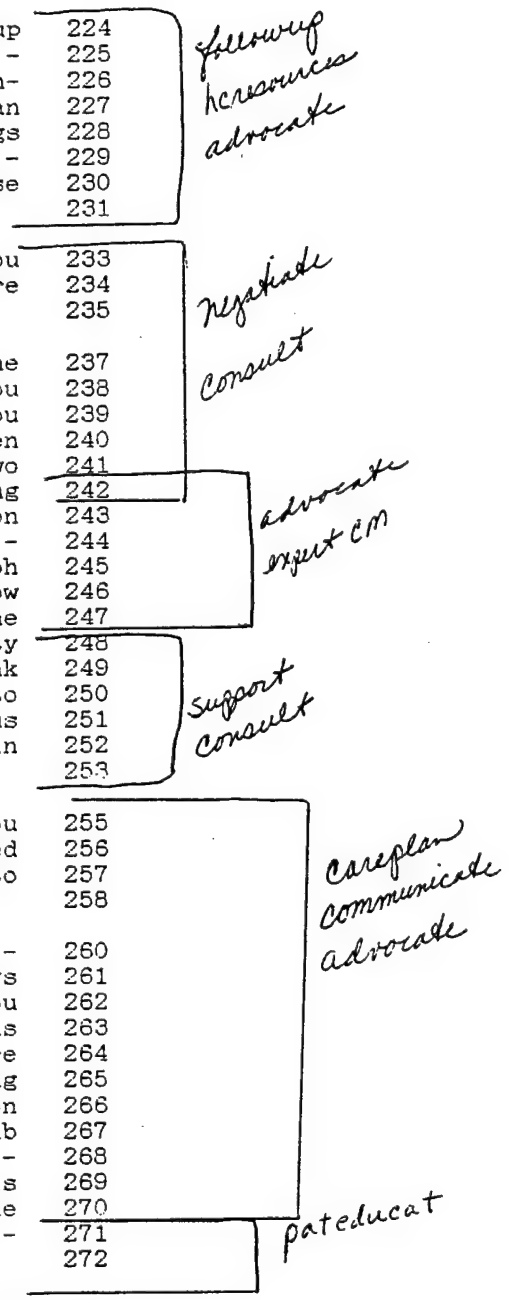
CC: If you did discover that - you 233
know - that duplicate tests were 234
ordered -how do you handle that? 235

86: Generally I talk to the team - the 237
medicine team that's on - there - you 238
know - just kind of let them know - you 239
know this guy's hematocrite has been 240
stable for - you know - the last two 241
days - I notice that you're ordering 242
CBC's - you know - is there a reason 243
for this - um - that I'm not aware of - 244
and - um - and generally they say - oh 245
- we just - kind of - forgot - you know 246
- and that's most of the time - in the 247
beginning there was a lot of animosity 248
-but - at this point in time - I think 249
they find us so amazingly helpful to 250
them that they - um - don't mind us 251
questioning them in anything in 252
particular. 253

CC: And then - like - if you 255
discovered that - maybe a PTT did need 256
to be ordered - are you allowed to 257
order it? 258

86: Yeah - generally I can order it - 260
without too much difficulty - I always 261
call them and say - hey - guys - you 262
know - uh - you mind if I write this as 263
a verbal - and they say - they're 264
totally up with that - the other thing 265
I have freedom to write is nutrition 266
consults - cardio-vascular rehab 267
consults - those kinds of things that - 268
just to make sure that the patient is 269
taken care of totally - um - that's the 270
other part of my non-case management - 271
part - is a lot of patient education. 272

CC: Um hm. Um - do you have any 274
problems getting the medical records? 275



APPENDIX G

EXAMPLES OF NURSE CASE MANAGER JOB DESCRIPTION

Clinical Case Manager

Position Code:

Position Summary

Responsible for independently/interdependently monitoring and coordinating the progress of a particular patient population and improved/cost effective patient care delivery.

Position Accountabilities

1. Identify patients appropriate for case management through referrals from hospital/medical staff and/or individual case findings resulting from chart review, health care provider interviews, and patient assessment.
2. Ensure critical path/plan of care and review is initiated by nursing and physician staff within one working day of admission.
3. Monitor patient's clinical progress to assure appropriate and timely care delivery during hospitalization and upon discharge.
4. Perform review functions for appropriateness of admission and continued hospitalization for third party payors as necessary to include contracted payors, Medicaid and CU Care. Provide information to payor via telephone or fax according to the requirements of the plan.

5. Collaborate with CU Care using pre-determined criteria to manage the acute, inpatient portion of treatment. Provide data to CU Care as requested for the purpose of utilization review trending and participate in process action teams to improve patient care when appropriate.
6. Collaborate with and serve as a resource for physicians and staff regarding patient progress. Participate in activities such as physician rounds, discharge planning meetings, and patient care conferences, etc., as needed.
7. Assist in coordination of ancillary services in order to efficiently and effectively meet patient needs. Intervene with other departments to facilitate patient services as needed.
8. Facilitate discharge planning efforts through early identification of high risk patients. Promptly notify social services/discharge planner of changes in patient's hospital course or discharge needs.
9. Assist staff with appropriate patient teaching and follow up/reinforce patient teaching to ensure patient family understanding.
10. Assist in the development and implementation of interdisciplinary critical paths for assigned patient population.
11. Identify patient care variances from the pathway/plan of care and collaborate with health team members to formulate plans for variance resolution.
12. Compile and analyze aggregate variances for specific patient populations. Report this variance data along with recommendations for improvement to appropriate care team members, nursing and quality management department members and others as designated.
13. Incorporate findings of variance analysis into unit/nursing/hospital quality improvement programs.
14. Serve as a patient advocate with third party payors to obtain services out of plan.
15. Identify, as well as participate in development and implementation of strategies to reduce resource consumption and length of stay for the case managed patient population.

16. Patient education:
    -Develop patient education materials
    -Provide Patient/Family education regarding health promotion; disease; life style alteration; tests, procedures; and medications.

17. Clinical Management:
    -Performs patient assessment through the continuum of care, (pre-admission, Inpatient, and post-discharge).
    -Phone triage for identified patient population
    -Monitor laboratory, procedure data, medications and hemodynamics.
    -Perform interim follow-up of lab tests with appropriate referral and follow-up.
    - Identify potential patients for Medical Clinical Research Studies.

Position Qualifications

Case Manager
Page 3

Minimum Education	License as a Registered Nurse in Colorado Bachelor's degree in Nursing required MSN may be required for specific patient populations
Minimum Experience	2 years of experience as a clinical case manager or as a registered nurse in the assigned clinical area with demonstrated clinical competence. This clinical experience must have taken place within the last five years of the nurse's career.
Skills: Administrative	Demonstrated excellence in interpersonal, written, and oral communication. Demonstrated ability to function independently and interdependently as well as show initiative in managing multidimensional patient and family situations.
Skills: Machine	Knowledge of a wide variety of medical equipment and instruments. Computer skills required.
Physical Demands	Requires full range of body motion including handling and lifting adult patients, manual and finger dexterity and eye-hand-foot coordination. Frequent standing and walking or other means of mobility for extended periods of time. Performs difficult manipulative skills (i.e., insertion of IV lines, etc.).
Physical Strength	Able to push/pull more than 50 lbs. Able to lift objects more than 20 lbs.
Vision Requirements	Near Acuity: ability to see clearly at 20 inches or less. Requires eye-hand coordination; keyboard, injections, etc.
Hearing Requirements	Able to hear normal sounds with some background of noise as in answering phone, intercom, etc. Able to distinguish sounds as voice patterns.
Environmental Conditions	Exposure to blood, body tissues, or fluids Exposure to hazardous waste materials Exposure to toxins, cytotoxins, or poisonous substances Exposure to loud or unpleasant noises Exposure to electromagnetic radiation as in CRTs (VDTs) Exposure to other hazardous materials such as chemicals Exposure to communicable diseases
Mental Requirements	Able to concentrate on fine detail with constant interruption. Attends task/function for more than 60 minutes. Able to understand/relate to theories behind several concepts.
Age Specific Considerations	Able to effectively monitor and coordinate the case management of specific patient populations representative of the age continuum from preterm through geriatrics.

Employee: _____ ***Date:*** _____

Employee # _____

Supervisor: _____ *Date:* _____

Human Resources: _____ *Date:* _____

THE ABOVE STATEMENTS ARE INTENDED TO DESCRIBE THE GENERAL NATURE AND LEVEL OF WORK BEING PERFORMED. THEY ARE NOT ALL RESPONSIBILITIES, DUTIES AND SKILLS OF PERSONNEL SO CLASSIFIED.

Case Manager

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Case Manager
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Supervisor: _____ *Date:* _____

Human Resources: _____ *Date:* _____

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Job Title:	Case Manager	Job Code:		Pay Grade:		Effective Date:	
Dept.:	Managed Care and Marketing	Dept. #:		Supervisor:	Asst. V.P. Managed Care & Marketing	Revision Date:	8-19-96

AGE OF PATIENTS: Indicate if the job requires working in a patient care area and/or treating patients: Ages: ____ through ____ Not Applicable ✓

GENERAL PURPOSE OF JOB: (Briefly describe the job's primary purpose or contribution to the department or organization.) Provide efficient and effective coordination and management of health care resources. Foster excellent provider relations. Provide excellent customer service and provide education to hospital staff and physicians regarding case management and utilization management.

EXPERIENCE REQUIRED (Including knowledge, special skills, equipment or tools, etc.): Minimum of 3 years experience in pediatric inpatient setting required. Case management / utilization management experienced preferred.

EDUCATIONAL REQUIREMENTS/SPECIFIED DEGREE/CERTIFICATES/LICENSES/REGISTRATIONS (List any that are required for the position): BS RN Nursing or equivalent clinical experience. Masters degree preferred.

SUPERVISORY RESPONSIBILITIES: Yes ☐ / No ☑ (Supervising includes authority to hire, discipline and terminate.)

PHYSICAL DEMANDS: On-the-job time spent in physical activities:	AMOUNT OF TIME				List duties that require the specified physical demands:
	Ø	<⅓	< ½	> ⅔	
Sit				✓	
Walk			✓		
Stand	✓				
Talk or Hear				✓	
Taste or Smell	✓				

Lifting required:	AMOUNT OF TIME			
	Ø	<⅓	<½	>⅔
Up to 10 pounds	✓			
Up to 25 pounds	✓			
Up to 50 pounds	✓			
Up to 100 pounds	✓			
Over 100 Pounds	✓			

Climb or Balance	✓				
Reach with Hands and Arms		✓			
Stoop, Kneel, Crouch or Crawl	✓				
Vision				✓	

List duties that require the specified lifting:

List the job's essential or most important functions and responsibilities. Include all important aspects of the job -- whether performed daily, weekly, monthly or annually; and any that occur at irregular intervals. This is not an exhaustive list of all duties, responsibilities or qualifications associated with the job. Performance standards to be based on these functions:

% of Time	Essential Functions (Usually 5-7)	Standards of Performance
	I. Assess all unit patients for medical necessity of hospitalization, continued stay, and need for catastrophic case management.	
	II. Discharge Planning.	
	III. Communicate with all internal and external members of the health care team, as necessary, to ensure the accomplishment of the goals to provide high quality, cost effective care and customer satisfaction.	
	IV. Collaborate with health care health care team to facilitate high quality, cost effective care.	
	V. Assist with investigation, review and resolution of third party payer denials/coding appeals.	
	VI. Collaborate with unit(s) to develop care paths and/or practice guidelines.	
	VII. Educate all members of the health care team on unit(s) about utilization and case management concepts.	
	VIII. Maintenance of Professional Standards.	
	IX. Evaluate the effectiveness of the case management/utilization management model.	

Prepared By: _____
Title Date

Approved By: _____
Department Head Date